REPORT

Final Report

Contract Number 282-98-0019 - Task Order 13

A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Title X Clinics

To

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Project Summary

In 2003, the Office of Population Affairs (OPA) contracted with the Battelle Centers for Public Health Research and Evaluation to conduct a study of family and intimate partner violence (FIPV) prevention activities in Title X-supported family planning clinics. The study included several research activities including visits to nine Title X-supported clinics, key informant interviews with clinic directors and clinic health care providers, key informant interviews with state and federal staff, a literature review and an evaluation of a FIPV resource guide that was developed to help integrate FIPV prevention programs into family planning clinics. These research activities were in support of three objectives:

- To assess the extent to which strategies used to implement FIPV integration have been acceptable to program providers, and whether program staff perceive them to be effective and sustainable.
- To identify the impact of FIPV prevention activities on the implementing organizations, and arrive at implications for the program on wider integration of FIPV activities in Title X clinics, including some measures of cost of the program to the clinic.
- To identify specific strategies that the OPA and collaborating agencies can utilize to raise awareness about FIPV and to achieve better integration of FIPV prevention activities into public family planning services.

This summary provides an overview of the study including background information regarding the impetus for this study, the data collection and data analysis methods used for the study and the findings from each evaluation activity. Finally, the findings across research activities are synthesized into conclusions regarding FIPV prevention activities in Title X-supported clinics and recommendations for facilitating the further integration of FIPV prevention into family planning clinics. The attached reports provide detailed information about each of the activities undertaken for the study.

Background

In 2001, the Centers for Disease Control and Prevention contracted with Battelle to conduct a nationally representative survey of clinic directors and clinicians at Title X-supported clinics regarding their FIPV prevention activities. The sample was stratified by Department of Health and Human Services (DHHS) region. A response rate of 93% for clinic directors and 78.4% for clinicians was obtained, with 843 clinic directors and 666 clinicians responding to the survey. Results from the clinic directors included:

- 83.3% of the clinics routinely screen for FIPV.
- 86.2% of the clinics provided brochures to clients on FIPV
- 55.5% of the clinics had written protocols about FIPV
- 45% of the clinics offered FIPV training during the previous 2 years and 36.7% provided FIPV training opportunities elsewhere

The intriguing results of this survey provided the impetus for the present study to develop a more in-depth understanding of FIPV prevention activities in selected Title X-supported clinics.

Design and Methods

To conduct a more in-depth study of FIPV prevention activities in Title-X supported clinics, OPA contracted with Battelle to undertake five research activities. These included:

- A literature review of peer-reviewed journals, published books and articles, documents produced by professional organizations, and web-based documents published from 1999 to 2005, with seminal documents published prior to 1999 included in the review. The focus was on FIPV and reproductive health, including contraception, pregnancy, sexually transmitted diseases and human immunodeficiency virus (HIV), with an emphasis on clinic considerations and documents. In particular, four types of clinical documents were sought out – protocols and guidelines for clinicians, tools for screening and prevention, clinical training methods, and programs and evaluated interventions for FIPV prevention. In total, 166 documents were included in the literature review set.
- Open-ended, unstructured, in-person interviews with staff from Title X-supported clinics including 9 clinic directors, 17 clinicians, 2 health educators, and a vice president in charge of training. Seven of the clinic directors were also clinicians. The clinicians interviewed were primarily nurse practitioners, but also included three physicians and several registered nurses and social workers. The interviews lasted between 20 minutes and two and one-half hours. Clinician interviews were usually shorter than clinic director interviews. Though unstructured, the interviews covered four primary areas of interest: clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs and collaboration with community organizations. Challenges and facilitators to identifying and responding to FIPV were also discussed.
- Visits to nine Title X-supported clinics with tours of the facilities. Clinics were selected and invited to participate in the study so that the final group achieved a mix of location, organization type and community type. The clinics are located in 9 of the 10 DHHS regions and included four county health departments, three Planned Parenthood clinics, and two community health centers. Five clinics served primarily urban or suburban populations and four clinics served primarily rural populations. All of the clinics were receiving Title X funds at the time of the visit. Two members of the research team visited each clinic. The clinic director conducted a tour of the facility, and the research team observed the waiting rooms, examination rooms, consultation rooms, restrooms, laboratories, and offices. The research team noted the clinic experience from the patient's point of view, looked for information (posters, brochures, flyers) about FIPV in clinic locations, and considered the privacy of each location where clients might disclose FIPV in writing or verbally. A description of each participating clinic as well as a summary of each clinic's FIPV practices is included in the attached report.
- Open-ended, unstructured telephone interviews with nine state employees who oversee the Title X program in their state and eight federal employees who are Program Consultants for DHHS regions across the United States. The state employees were chosen because they represent the same states where visits and tours of Title X-supported clinics were conducted and where the health care providers and clinic directors are employed. One state in each of 9 of the 10 DHHS regions was represented. The federal Regional Program Consultants represented 8 of the 10 DHHS regions. Clinic policies and

protocols, routine screening procedures for FIPV, health care provider and staff training programs, and collaboration with community organizations were discussed with the state and federal employees. In addition, they were asked about the challenges and facilitators to identifying and responding to FIPV.

- An assessment of a Resource Guide for integrating FIPV services into family planning clinics. The Resource Guide was produced by JSI/Denver for OPA and distributed by OPA to all state Title X grantees. The grantees in turn distributed the guide to Title X-supported clinics in their states. To evaluate the Resource Guide, telephone interviews were conducted with six state grantees (drawn from states where clinic visits were conducted) and two clinicians (drawn from clinics where visits were conducted), as well as a communications expert with experience in developing FIPV products. Respondents were asked about the content and comprehensiveness of the Resource Guide and how they would use the guide. Respondents were also asked to make recommendations about improvements to the next version of the Resource Guide. The findings from this assessment do not directly relate to project objectives but are summarized because they relate to integrating FIPV prevention programs into Title X-supported clinics.

All interviews were conducted using interview guides and were recorded and later transcribed for analysis. With the exception of those conducted for the Resource Guide interviews, all transcripts were content analyzed using qualitative analysis software.

Findings

Below the findings from each data collection activity are summarized. More detailed information about the data collection, analysis and findings can be found in the individual reports developed from each activity.

Literature Review. Battelle's review of FIPV published papers and web-based documents written from 1999 to 2005 uncovered a number of findings that have important implications for Title X-funded family planning clinics. Some of the important findings are summarized below.

- None of the articles or documents included in this review substantially considered men either as partners or concerned others (e.g., fathers, brothers, or friends). Of the research and evaluation articles reviewed, none of them included a male viewpoint or direct reports of male characteristics or behavior. The focus of the review on reproductive health and clinical issues accounts for most of the articles being about women or based on reports made by women. However, given that men are the primary perpetrators of violence against women, that they occasionally experience FIPV themselves, and that they may have women whom they care about at risk for abuse, men seem to be a missing factor in the area.
- Harm to the patient coming about as a result of FIPV prevention activities is an important consideration. For example, it is possible that direct harm or violence could come to a patient as a result of a clinician's screening or prevention activities by triggering violent behavior from an abusive partner. Indirect harm could come about by an abusive partner prohibiting the patient from further medical care after an initial screening for FIPV or provision of related written materials to the patient. In the literature review, there were no studies found suggesting that screening and prevention activities are harmful or

dangerous for patients, although there seems to be a paucity of research specifically directed at this problem. Another area where harm could result is from the consequences of mandatory reporting laws such as those found in California and Colorado. These states have laws requiring health care providers to report suspected cases of FIPV to law enforcement. Supporters of mandatory reporting laws believe that they will enhance patient safety, improve the health care system's response, and improve surveillance data collection but detractors are concerned that mandatory reporting will deter women from getting help and that the perceived breach of patient-provider confidentiality will weaken this important relationship. In addition, some detractors of mandatory reporting argue that reporting FIPV could put a patient in danger of an attack from their partner as a result.

- Clinicians perceive a number of barriers related to screening and prevention that inhibit their willingness to screen patients for FIPV, yet clinicians have an enormous role in the identification of FIPV and in helping their patients cope with the situation. One of the most pressing provider-specific issues is the necessity and availability of training in FIPV prevention for providers. Training increases screening and detection; and although the rate of FIPV training among providers is increasing, it is not particularly high. It also appears that more providers are interested in training than there is available to them.

Findings from the literature review also demonstrate that the evidence base in regard to screening and prevention of FIPV by clinicians needs to be strengthened for universal, appropriate, and effective screening by clinicians to become a reality. In 1996, the U.S. Preventive Services Task Force reviewed the available evidence and could not make a recommendation encouraging universal screening of patients for FIPV because of a lack of evidence. In 2004, the Task Force again reviewed the available evidence and again could not make a recommendation encouraging universal screening because of a lack of evidence. Battelle's review of the literature identified a number of areas where the evidence base for FIPV screening and prevention by clinicians could be strengthened. Doing so will ensure that recommendations and guidelines from professional organizations and government agencies will result in effective screening methods and the prevention of FIPV, and that the Task Force's next review will result in a decision based on existing evidence.

Clinic Visits and Interviews with Clinic Directors and Clinicians. Visits were conducted by Battelle's research team to nine Title X-supported family planning clinics. While there, interviews were conducted with clinic directors and clinicians regarding FIPV prevention activities. Findings from the site visits and interviews included:

- Recognition of FIPV as a problem that the clinic should address varied among the clinics and was often tied to the states' or the communities' concerns about FIPV or the particular interest of one or more staff members. The state, either through active FIPV prevention programs or legislation such as mandatory reporting of FIPV, was an important factor in the Region II, V, VI, VII, and IX clinics. Seven of the nine clinics also had one or more staff members who expressed interest in and dedication to FIPV prevention. These two factors together seemed to promote the most extensive FIPV prevention programs that were encountered. Three of the clinics' FIPV prevention programs consisted only of written screening questions and a concerned clinician. Staff in these three clinics were concerned about FIPV but noted a lack of resources, their community's lack of concern about FIPV, or the stigma associated with FIPV as limiting factors.

- All of the clinics conducted written screening of all patients at intake and then at least annually after that. Verbal screening is done when the patient indicates FIPV on the written screener, when there is some evidence of abuse (e.g., bruises, cuts) or when the clinician suspects or intuits that FIPV may be a concern. Eight of the clinics displayed posters about FIPV or had brochures or information readily available for patients. These were sometimes in the waiting rooms but often in the exam rooms or ladies' restrooms. Training was important to the clinicians. Six of the clinics have formal training programs, although the methods and formats varied from ½-hour videos to two-day trainings in FIPV. Several sites conducted updates about FIPV during regular meetings or in-services. Several clinicians and clinic directors expressed the desire for additional training in FIPV prevention.
- All of the sites collaborated with community agencies to some extent. One clinic had a unique approach, working with schools, unions, and local businesses to raise awareness about FIPV. Two clinics were part of domestic violence community coalitions. All of them had contacts with a domestic violence shelter or crisis center and referred clients to these organizations. At clinics with formal FIPV prevention training programs for staff, the domestic violence organizations often took part in the FIPV prevention training as teachers or guest lecturers.
- A number of useful strategies emerged to better integrate FIPV prevention and services into the clinics' provision of care including:
    - Recognizing that clinicians are a key factor in screening for and identifying FIPV. Clinicians working at clinics with basic FIPV prevention programs still made a significant contribution to FIPV prevention as caring and interested health care providers. Most were open to additional training in FIPV, and clinicians in rural areas were particularly interested in ways to obtain professional training in FIPV prevention.
    - Organized training programs can be brief, such as a one or two hour in-service meeting. Clinicians appreciated training that helped them to overcome anxiety about talking to a patient about FIPV. Training programs also stressed that helping someone experiencing FIPV sometimes took longer to get results than other concerns and that sometimes resolution never occurred.
    - Community collaborations were important to most of the clinics' FIPV prevention programs. Collaborators provided materials to display and distribute to patients and also provided training to the clinic staff. They further helped the clinic respond to patients in crisis, sometimes immediately. Even if the community collaborators were not called by clinicians to help with a particular patient, they were important places for patient referral.

Key Informant Interviews with State and Federal Staff. Telephone interviews were conducted with representatives from grantees in the nine states where Battelle conducted site visits and Regional Program Consultants from eight of the nine regions where Battelle conducted site visits. Findings included:

- Views about integrating FIPV screening and prevention into Title X-supported clinics varied greatly among the interviewees. Most agreed that the nature of care given at

family planning clinics has been shifting in recent years from a clinical focus on reproductive health to a more comprehensive public health approach to care. Respondents attributed some of this shift to research indicating that for many patients, the Title X clinic is their only contact with the public health or the medical system. This change in approach to health care delivery was welcomed by most of the interviewees who felt it was a change for the better. However, a few interviewees felt that it distracted clinic staff from the issue of reproductive health.

- Most of the barriers to successful integration of FIPV prevention into Title X-supported clinics centered around a lack of resources including money, time and staff. Time and financial constraints were mentioned most frequently but other resource-related barriers included (1) a lack of local resources such as safe houses, counseling centers, etc. to respond to FIPV cases; (2) a lack of staff expertise in FIPV prevention; (3) competing demands of other health issues on providers' time and clinic resources; and (4) the absence of appropriate training in FIPV prevention. Also mentioned as barriers to successful integration of FIPV prevention were local politics involving family planning, language barriers between providers and patients, and the inability of the clinic or clinicians to protect victims' privacy and confidentiality.
- Four facilitators for successful integration of FIPV screening and other prevention activities into Title X-supported clinics emerged from the off-site key informant interviews. These were: (1) using a client-centered approach to services where the clinician is prepared to respond to the client's needs including FIPV; (2) approaching FIPV as part of a comprehensive prevention program that deals with several inter-related issues such as substance use, unintended pregnancies, and violence (including FIPV); (3) increasing awareness about FIPV at the state, regional, and clinic levels by raising it to a higher level of priority than other issues; and (4) having a staff person, such as a social worker or a Sexual Assault Nurse Examiner, at each clinic to support the clinicians by serving as a FIPV expert.

Evaluation of the Resource Guide to Integrate FIPV Activities into Title X-supported Clinics. The Resource Guide was reviewed by six state grantees and two clinicians as well as a communications expert with experience in FIPV materials. The Resource Guide consisted of a large binder with eight sections providing a basic introduction to FIPV, training resources, protocols and policies, patient and client resources, referral resources, information about reporting and information about educational materials. A CD-Rom of the materials included in the Resource Guide was also provided.

The reviewers of the Resource Guide generally found that the content of the Guide was what was needed and expected of a resource of this type. The state grantee and clinician reviewers saw the Resource Guide more as a management or training tool, rather than a clinical resource, owing primarily to its size and style of organization. Reviewers suggested that the Resource Guide is most effective if used as a group training guide. Delivering it to the clinics as a formal training tool will enable clinicians to build upon their current knowledge of FIPV, yet not overwhelm them with material that they do not have time to utilize. Specific recommendations for future iterations of the Resource Guide included:

- Providing more materials geared directly towards family planning organizations such as those produced by the American College of Obstetrics and Gynecology

- Adding an additional chapter on screening techniques for special populations
- Including an enhanced version of the CD-Rom that would allow users to adjust the forms and templates as needed and use links to access the resources via the internet
- Update the resources and research with each new iteration of the Resource Guide and include the source, author and date of publication of each document

Each of the above research activities contributed to a Promising Practices Report intended for clinics to use to help them integrate FIPV prevention into their practices. This Promising Practices report is also included with the attached documents.

Recommendations

Based on the research and evaluation activities described above, several recommendations can be made to facilitate the integration of FIPV prevention into the services offered at Title X-supported family planning clinics.

- *Clinic programs in FIPV prevention do not need to be elaborate but commitment to FIPV prevention is a key feature in successful integration.* During the site visits, Battelle encountered a wide range of FIPV prevention programs. Training for at least one clinician is important, as is the commitment of a key individual, the managing agency, or the state or state grantee. Efforts beyond this such as full staff training programs or community coalitions were important but some of the programs encountered in this study were fully-integrated into the clinic's services and consisted of one concerned individual and a community partner.
- *A number of FIPV products and services are available from outside organizations that the Title X-supported clinics can make use of in their FIPV prevention programs.* These products and services included brochures and materials for clients as well as prepackaged protocols and instruments. Training programs are also available. During the site visits, Battelle researchers found that virtually all the clinics used some materials, instruments or training resources obtained through outside sources.
- *Community resources and partnerships are critical to integrating FIPV prevention programs into clinic services.* Most Title X-supported clinics do not have the resources to work with clients experiencing FIPV long-term. In many cases, the services needed by the clients are also beyond those offered by the clinics. Strong, reliable community partners offer support to the clinics in terms of referrals for patients, allowing the Title X clinics to be able to respond immediately and effectively to clients experiencing FIPV. These community partners also provide training to clinic staff in FIPV prevention as well as materials and information for clients.
- *Clinicians are the center of the FIPV prevention activities and one of the key factors in the successful integration of FIPV into clinic services.* The role of the clinician was a constant recurring theme encountered during the research activities. One concerned clinician can make a difference in a clinic's FIPV prevention program. However, clinicians experience barriers to addressing FIPV with their patients, and training can help overcome some of the barriers. During the site visits, many clinicians said that training in FIPV was important to them. However, training may not be available to many

clinicians because they are working in rural locations or because their clinic does not have the staff or financial resources to send them to training or to conduct training on their own. One possible approach would be to bring the training to the clinicians (as suggested by several state and federal staff), thus reducing the resource burden of the training to clinics.

- *Provide updates about FIPV to the clinics and reinforce the importance of FIPV prevention to the range of services provided by the Title X-supported clinics.* Research in clinical interventions for FIPV prevention showed that brief training programs for clinicians did not have sustainable outcomes, yet long, intense training programs are unlikely to be suitable for clinicians at the Title X-supported clinics. Providing updates and reminders about the importance of FIPV prevention to clinics may help to sustain the effects of brief training programs.

Conclusion

This summary is based upon the research activities conducted for the *Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Selected Title X-supported Family Planning Clinics.* The findings presented above are drawn from the five attached reports – the literature review of FIPV and reproductive health, the report of site visits and key informant interviews with clinicians and clinic directors, the report of key informant interviews with state and federal staff, the report of the evaluation of the Resource Guide for integrating FIPV prevention services into Title X-supported clinics and the report of promising practices for integrating FIPV prevention services into Title X-supported clinics.

Promising Practices for Title X-supported Family Planning Clinics: Preventing Family and Intimate Partner Violence

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The study team would like to thank the many clinic directors and health care providers who participated in the study for their thoughtful comments and reflections about family and intimate partner violence prevention in their clinics, as well as for their hospitality in hosting the study team during the site visits. The promising practices suggested in this document could not have been identified without their help. In addition, we would like to thank the Regional Program Consultants and state Title X grantees who were key informants for the project and provided insights and ideas about family and intimate partner violence prevention from the regional and state perspectives.

Introduction

Family and intimate partner violence (FIPV) includes acts of physical, sexual, and psychological violence and deprivation, occurring largely between family members and intimate partners, usually although not exclusively taking place in the home.[1] FIPV encompasses child maltreatment, intimate partner violence and elder abuse. Victims of FIPV are primarily women and children, although men can also be victims. Those at particular risk for violence are young women between the ages of 16 and 24[2] and women living in the lowest income households.[3] Pregnant women are also at high risk for FIPV, with physical abuse more likely to occur for the first time or to escalate during pregnancy.[4]

Conducting FIPV prevention activities in Title X-supported clinics offers a unique opportunity to reach populations particularly vulnerable to FIPV. The Title X program is the only federal program devoted to providing access to contraceptive and reproductive health services to all who need them, with priority given to low-income and uninsured persons. The Title X program provides reproductive health services to approximately 5 million people each year. Nearly 80% of clients are under the age of 30. For many, Title X clinics are the first point of access to the health care system and to primary providers of health care services.[5]

In 2001, a survey of 843 Title X-supported clinics by the Centers for Disease Control and Prevention and Battelle found that 83% of these clinics routinely screen for FIPV. More than one-half have written protocols, procedures, or guidelines for identifying, treating, and referring clients who are experiencing FIPV.[6] To assist the majority of Title X-supported clinics undertaking FIPV prevention activities in enhancing their programs, and to encourage the remaining clinics to institute FIPV prevention activities, the Office of Population Affairs and Battelle conducted a study to identify promising practices in FIPV identification and prevention.

What is a Promising Practice?

A promising practice is a program, activity, or strategy that has worked in one organization and shows promise of becoming a best practice with long-term sustainable impact.[7] Identifying a promising practice in one setting and disseminating it to other settings where it can be replicated helps to address an issue – in this case FIPV – in the new setting while saving valuable resources such as time and money. Disseminating promising practices in FIPV prevention in Title X-supported clinics will help clinic directors, staff and health care providers more successfully identify clients experiencing FIPV and respond to the needs of these clients. In the long run, disseminating

promising practices may prevent new cases of FIPV and eliminate or ameliorate existing cases of FIPV, thereby saving valuable clinic resources.

Each of the promising practices suggested in this document has been considered against criteria recommended by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to evaluate best practices.[8] These criteria are:

- *Effectiveness* → Does the practice work? Does it produce the intended outcome?
- *Ethical Soundness* → Is the practice within the bounds of accepted conduct or rules of behavior? Can it be enacted using the resources of the organization? Is the potential for causing harm nonexistent or minimal?
- *Relevance* → Is the practice directly related to or in support of the objective? Does it 'fit' within the operating environment of the organization or agency?
- *Efficiency* → Does the practice produce the desired outcome with reasonable expenditure? Is the benefit/cost ratio favorable?
- *Sustainability* → Can the practice be implemented over time and continue to be effective? Does the practice build capacity within the organization or among beneficiaries?

To contribute to the identification and prevention of FIPV in Title X-supported clinics, promising practices are suggested in four areas:

- *Training* → Training health care providers and other clinic staff in screening for FIPV and responding to the needs of clients who are experiencing FIPV is an important part of any clinic's prevention activities. Health care providers often supply clients with the support and the means to prevent FIPV. Training assists health care providers in these activities.
- *Screening and Intake* → Screening for FIPV takes many forms. Most clinics screen patients with one or more questions on an intake form. Many clinics and health care providers supplement the written screening tool with verbal questions and conversations with clients.
- *Clinical Evaluations* → Many health care providers maintain that identification of FIPV typically occurs during the course of the exam and other interactions with patients rather than during screening.
- *Follow-up and Referral* → Helping a client move away from a situation where they are experiencing FIPV can be a lengthy and difficult process. Providing long-term support is a necessary feature of the process.

Real-world practices identified at the participating Title X-supported clinics are highlighted in information boxes throughout this document.

Identifying Promising Practices

Several methods were used to identify the promising practices recommended in this document. These included interviews with health care providers and clinic directors at Title X-supported clinics, interviews with state and federal employees who are knowledgeable about the Title X program and FIPV, and site visits to Title X-supported clinics. Information collected during these activities was supplemented by a literature review of FIPV and reproductive health issues with an emphasis on clinical practices and considerations.

Interviews with Health Care Providers and Clinic Directors

Open-ended, unstructured, in-person interviews were conducted with 9 clinic directors, 17 clinicians, 2 health educators, and a vice president in charge of training. Seven of the clinic directors are also clinicians. The clinicians interviewed are primarily nurse practitioners, but also include three physicians and several registered nurses and social workers. The interviews lasted between 20 minutes and two and one-half hours. Clinician interviews were usually shorter than clinic director interviews. Though unstructured, the interviews covered four primary areas of interest: clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs, and collaboration with community organizations. Challenges and facilitators to identifying and responding to FIPV were also discussed.

Interviews with State and Federal Employees

To obtain a different perspective on FIPV prevention activities in Title X-supported clinics, open-ended, unstructured telephone interviews were conducted with 9 state employees who oversee the Title X program in their state and 8 federal employees who are Program Consultants for Department of Health and Human Services (DHHS) regions across the United States. The state employees were chosen because they represent the same states where visits and tours of Title X-supported clinics were conducted and where the health care providers and clinic directors are employed. One state in each of 9 of the 10 DHHS regions was represented. The federal Regional Program Consultants represented 8 of the 10 DHHS regions. Similar to the health care provider and clinic director interviews, clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs, and collaboration with community organizations were discussed with the state and federal employees. In addition, they were asked about the challenges and facilitators to identifying and responding to FIPV.

Tours of Title X-supported Clinics

Visits to 9 Title X-supported clinics were conducted and tours taken of the facilities. Clinics were selected and invited to participate in the study so that the final group achieved a mix of location, organization type and community

type. The clinics are located in 9 of the 10 DHHS regions and included four county health departments, three Planned Parenthood clinics, and two community health centers. Five served primarily urban or suburban populations and four served primarily rural populations. All of the clinics were receiving Title X funds at the time of the visit. Two members of the research team visited each clinic. The clinic director conducted a tour of the facility, and the research team observed the waiting rooms, examination rooms, consultation rooms, restrooms, laboratories, and offices. The research team noted the experience from the patient's point of view, looked for information (posters, brochures, flyers) about FIPV in the clinic locations, and considered the privacy of each location where clients might disclose FIPV in writing or verbally. A description of each participating clinic as well as a summary of each clinic's FIPV practices concludes this document.

Literature Review

The research team conducted a literature review of peer-reviewed journals, published books and articles, documents produced by professional organizations, and web-based documents published from 1999 to 2005, although a few seminal documents published prior to 1999 were also included in the review. The focus was on FIPV and reproductive health, including contraception, pregnancy, sexually transmitted diseases and human immunodeficiency virus (HIV), with an emphasis on clinic considerations and documents. In particular, four types of clinical documents were sought out – protocols and guidelines for clinicians, tools for screening and prevention, clinical training methods, and programs and evaluated interventions for FIPV prevention. In total, 166 documents were included in the literature review set.

The promising practices suggested in this document are based primarily on the experiences, practices and ideas of the health care providers and clinic directors who participated in the study but are supplemented by the observations and ideas of the state and federal employees who participated as well as the information gleaned from the review of the literature.

Promising Practices – Training

Health care providers represent one of the most important factors in identifying and responding to FIPV. The study team found that even at clinics with only basic FIPV prevention programs, clinicians still made a significant contribution to FIPV prevention as caring and knowledgeable health care providers. Training health care providers in screening for FIPV, awareness of the risk factors for FIPV, recognizing the signs of FIPV, and responding to the needs of clients experiencing FIPV is arguably one of the most important steps clinics can take to prevent FIPV. Of the clinics visited for this study, six of the nine had formal training programs for health care providers. The methods ranged from ½-hour videos to multi-day programs taught by staff from community organizations specializing in FIPV.

Real-World Practice: Region V
This clinic is located close to the local YWCA, which has a crisis center for domestic violence. The clinic works collaboratively with the YWCA, with each providing referrals to the other. Training is provided to clinic staff by representatives from the crisis center. The training includes role playing and guest speakers.

The most common training method was through annual one- to two-hour in-service presentations or lunch meetings, with periodic updates provided through the same means. The clinics participating in the study typically developed their own training, although several pre-packaged training programs for health care providers are available for less than a few hundred dollars. Health care providers were open to FIPV training, and those that had received training found it to be useful.

Key Training Elements

Although FIPV has physical manifestations and medical implications, FIPV is dissimilar in many ways to other conditions that health care providers may encounter while treating patients. FIPV has social,

Real-World Practice: Region IX
This clinic trains all clinicians and frontline staff using a training program developed from guidelines provided by Planned Parenthood of America and incorporating state-specific requirements. The training includes role playing and discussions of the social, policy, and medical aspects of FIPV. Training is usually held in October to support "Domestic Violence Awareness Month" and is augmented by periodic training as needed.

behavioral, psychological and economic factors that make resolution of FIPV difficult. Health care providers experience barriers when dealing with FIPV such as fear of offending patients, cultural and communication differences, fear of endangering patients, lack of information about resources for patients experiencing FIPV, limited time to work with patients experiencing FIPV, fear of legal involvement, and frustration about how difficult FIPV can be to 'fix.'[9] Promising training programs incorporated elements that recognized these factors such as:

- Helping health care providers overcome anxiety about talking to clients about FIPV
- Including role plays and practical approaches and tips to working with clients experiencing FIPV
- Focusing on improving provider self-efficacy about screening for and responding to FIPV
- Stressing the fact that helping clients experiencing FIPV sometimes takes longer to achieve results than is true for other health concerns and that resolution sometimes never occurs but that clients still need support
- Teaching health care providers about making safety plans with clients
- Incorporating frequent updates and reminders as research shows that brief, one-time trainings are sometimes ineffective[10]
- Including input from local experts in FIPV and representatives from community organizations providing FIPV services

Real-World Practice: Region I
FIPV training for all staff is incorporated into an annual 'training day.' Protocols and reporting requirements are reviewed and guest speakers are invited to talk about FIPV. Updates are provided throughout the year during lunch meetings.

Promising Practices – Screening and Intake

Most clients' first encounter with a clinic's FIPV prevention program is during intake and screening. Every clinic that participated in this study uses one or more standard questions (either written or verbal) to screen for FIPV. These questions are administered at initial intake and repeated at least annually for most clinics. Some clinics repeat the questions at every visit. A second verbal screening with more in-depth questions, or screening by a health care provider, occurs when the client indicates abuse on the intake form or the health care provider suspects violence. Procedures for the second screening tend to be unique to each clinic. It is typically done by the primary health care provider but some clinics employ social workers, social service coordinators or Sexual Assault Nurse Examiners to talk to clients who are at-risk for FIPV.

Real-World Practice: Region IV
This clinic subscribes to a 'language line' where for a small fee – charged by the minute – clients can be screened in their first language over the telephone.

The greatest challenge noted by the health care providers and clinic directors who took part in this study was ensuring the privacy of clients during standard screening and intake procedures. Privacy and confidentiality are always important considerations in providing health care but especially important with FIPV because a loss of privacy or confidentiality could put a client at risk for violence. All of the clinics visited by the study team take actions to protect clients' privacy. Clients are usually screened in private as standard procedure or moved to private areas when FIPV is suspected. Some of the clinics the study team toured have areas where clients and providers can be overheard. Health care providers are aware of this and have methods to overcome the lack of privacy. For example, in one clinic where an exam room is not private, the health care provider completes the physical examination in one room and then moves the patient to another for 'consultation,' portraying this as a standard procedure.

Real-World Practice: Region III
This clinic, like many others, has an interior waiting room for partners and family that is just outside the exam room. To ensure client privacy, music can be played in this waiting room, obscuring any client-provider conversations.

Promising Practices – Clinical Evaluations

After screening and intake, clients are seen and examined – usually when alone – by a health care provider. Most of the health care providers who took part in this study see this as the primary opportunity to talk about FIPV and assess clients' FIPV risk. These health care providers are skeptical about the truthfulness of clients' responses to FIPV screening questions, and some research suggests that this skepticism is warranted.[11] Clients are sometimes reluctant to admit FIPV in standard screening questions and, when they do, the admission often refers to a past situation. Promising practices related to clinical evaluations include using: standard no admittance policies for partners and families; in-home programs as an opportunity to identify FIPV; health care provider experience and instincts; and designating one or two key people in a clinic to respond to FIPV cases.

Real-World Practice: Regions V, VII, and IX
All three Planned Parenthood clinics have strict no admittance policies – only clients are allowed in the examination room with the health care provider. Region VII will make exceptions at the patient's request but only after they have been seen alone. Region V will also make exceptions for prenatal visits. Strict policies such as these eliminate the need to finesse time alone with a client who is at-risk for FIPV.

Nearly all of the health care providers the study team spoke to, particularly those most experienced in FIPV, mentioned using experience, close observation and their clinical 'instincts' to identify FIPV in their clients. Aside from physical signs such as abrasions, bruising and swelling on the face, abdomen, breasts, arms and hands, clinicians also looked for signs such as:

- Failure to make eye contact
- Fear of being alone with the clinician and other clinic staff
- Flat affect
- Following instructions too carefully
- Extreme discomfort or pain during vaginal exams
- Dislike of being touched in any way
- Frequent visits for unexplained complaints
- General dislike of or defensiveness about screening questions
- Evasiveness or limited answers to questions
- Alcohol or drug abuse
- Frequent changes in residence or living situation
- Extreme concerns about privacy and confidentiality
- Patterns of communication and non-verbal behavior between partners who are present during the visit

Some clinicians said they "just know" something is wrong and use their experience and a caring manner to help the client reveal the situation in her/his own way.

Real-World Practice: Regions VI and X
The clinics in both regions provide services to rural populations. Both administer state-funded programs for at-risk families where home visits are made by a nurse/case manager periodically for a year or more. The health care providers use the trust and rapport built over the long term as well as in-home observations to identify and respond to FIPV.

In many of the clinics the study team visited, one or two individuals are the experts or 'go to' people for FIPV. This may be an artifact of the procedures used to identify clinics that were asked to participate in the study because all the clinics asked were known to be undertaking some FIPV prevention activities. Possibly these clinics agreed to participate because of a common interest in or concern about FIPV by someone at the clinic, and these individuals were naturally the clinic's FIPV expert.

Nevertheless having someone who has training and expertise in FIPV is a useful resource. Sexual Assault Nurse Examiners, social services coordinators, social workers, and clinic directors served in this role. These individuals support health care providers by screening at-risk clients or those whom clinicians identified as suspect FIPV cases, working with clients by providing information and referrals, and making safety plans with clients experiencing FIPV. The FIPV experts also provide FIPV training and updates to other staff as well as interacting with community organizations specializing in FIPV. For example, the clinic in Region V has hired an advocate from a local rape crisis center to work as their resident outreach worker. The clinics in Regions I, V, VI, and VII have each hired a Sexual Assault Nurse Examiner – on a full- or part-time basis – to assist in providing services to clients experiencing FIPV.

Promising Practices – Follow-Up and Referral

Methods for following up with clients identified as experiencing FIPV and providing referrals to agencies that provide services to individuals experiencing FIPV are critical components of an FIPV prevention program. Yet these are challenging activities for Title X-supported clinics and health care providers because they often require already scarce resources such as time, staff, space and money.

Collaboration with organizations and other agencies that specialize in providing FIPV and other services beyond those offered by the Title X-supported clinic is among the most important methods of providing follow-up and referral services to clients experiencing FIPV. In essence, community collaboration represents a means for clinics to extend their services to include the ongoing support that clients may need. All of the clinics that took part in this study rely on some type of community collaboration to assist them in their FIPV prevention activities. The rural clinics found identifying collaborators to be more challenging than did the urban clinics because of the limited number of organizations in their respective areas. Clinicians in rural areas, as well as state and federal staff, noted this as a particular concern with FIPV as safe houses and crisis centers are few in these communities and their locations sometimes well known to all residents. Despite this limitation, all of the rural clinics had community partners. The Region II clinic (an urban clinic) is featured in the Real-World Practice box because it is part of an anti-violence community coalition. Other community collaborations include:

Real-World Practice: Region II
This clinic is part of a community coalition that addresses violence among its activities. Members include safe houses, law enforcement, churches, other health care agencies, violence prevention groups and victim's assistance agencies. In addition to mutual referrals and training, the coalition members work together on neighborhood meetings, employee training programs and health education.

- The Region I clinic partners with the local shelter and the state coalition against sexual and domestic violence.
- The Region III clinic works with local businesses and the local college to raise the community's awareness about FIPV.
- The Region IV clinic works with the sheriff and hospital systems in neighboring communities on issues involving children.
- The Region V clinic partners with the YWCA and works with a mental health clinic, a substance abuse center and a rape crisis center on particular cases and mutual referrals.

- The Region VI clinic works with the local hospital and schools, the safe house, and local churches to provide services for women and children in crisis.
- The Region VII clinic refers cases to two local crisis centers and works with local schools and some PTAs to raise awareness about FIPV.
- The Region IX clinic partners with a women's anti-violence empowerment organization on staff training as well as working with youth groups and Hispanic and Asian community organizations on other activities.
- The Region X clinic works with a women's empowerment organization, a family support group and two safe houses to respond to FIPV cases in the community.

In addition to working with community partners to extend their services, clinics and health care providers employ practices that allow them to follow up with clients about whom they are concerned. For example, clinics use a variety of approaches when recording FIPV on a patient's chart. Some elect to record nothing about FIPV to protect patients' privacy, relying on health care provider memory to follow-up with patient at the next visit. By making no entries, there would be no record of the FIPV if the charts were viewed by an unauthorized person, stolen or subpoenaed. Other clinics use coded entries to record FIPV on the chart so that only staff can understand the entries. Then at a later appointment, any health care provider can follow-up with the client. Still others use a code known only to patients and designated health care providers. Coded records are useful particularly when computerized records are kept, preventing unauthorized access to FIPV records. The Region II clinic uses an integrated computer program for screening and records management. FIPV records are password-protected and accessible to be used for follow-up with clients but cannot be accessed by anyone who is not authorized. To maintain the client's privacy and safety further, this clinic also establishes an alternate address to send correspondence and alternate contact information to reach the client following identification of FIPV.

Summary of Participating Clinics

Clinic A: County Public Health Department

Location and Population Density: City location serving a rural population
Race/Ethnicity of Population: Mixed Hispanic and Native American
FIPV Activities

- Training: A 1-2 day training curriculum is provided to clinicians annually by the state. This training was developed by the state and in accordance with federal guidelines. Training updates are incorporated into monthly staff meetings. As a rural clinic, staff must travel some distance to attend trainings.
- Screening and Intake: All patients are screened at initial intake, and annually thereafter, as part of the state health history form.
- Clinical Evaluation: If abuse is identified or suspected, the health care provider privately and verbally reviews the intake form with the patient in the exam room and discusses indication or suspicion of abuse. Also all prenatal and postpartum visits include verbal screening during each visit.
- Follow-up and Referral: After abuse is indicated, the nurse manager meets with the patient in a private office after the exam and offers counseling and referral information. The patient is provided with options about what to do and where to go when domestic violence occurs. Follow-up occurs after the exam when the patient's situation is deemed very serious and the nurse is concerned about the patient's safety and well-being.

Clinic B: Community Health Center

Location and Population Density: City location serving a rural population
Race/Ethnicity of Population: Primarily Anglo
FIPV Activities

- Training: Formal training in FIPV is provided annually to all staff at the clinic. This training includes a review of protocols and reporting laws and a presentation about FIPV by a guest speaker from a community partner. Staff members also receive updates on FIPV issues during lunch meetings. These updates last about one hour and are conducted quarterly. For the future, health care providers have requested additional training in the form of "worst-case scenario" role plays.
- Screening and Intake: All patients are privately screened with a written questionnaire in the exam room by the medical assistant at each visit, time permitting.
- Clinical Evaluation: Verbal screening is performed by the health care provider during the exam in cases where the patient has either indicated abuse or the clinician suspects abuse. Information pertaining to FIPV is entered into the chart in code and stored in a locked cabinet apart from the patient's medical file for protection purposes. Computer records are password-protected.
- Follow-up and Referral: For patients identified as having experienced FIPV, the clinician arranges a meeting with the social worker to perform a safety assessment. This assessment is used to identify whether or not it is safe for the patient to return home. The social worker then makes appropriate referrals to community partners.

Clinic C: Family Planning Clinic

Location and Population Density: City location serving an urban population
Race/Ethnicity of Population: Primarily Anglo
FIPV Activities

- Training: All staff members are given the opportunity to attend conferences and lectures on topics related to FIPV. Clinicians can attend both state-sponsored training and local training. Some nurses also attended a DHHS conference that focused on FIPV. Local training is provided by the YWCA and takes 50-60 hours to complete. The curriculum includes onsite training, role playing, general education and lectures by guest speakers. Staff spoke positively about the training they had received, but expressed a desire for additional educational opportunities focused on FIPV.
- Screening and Intake: Screening occurs at initial intake, and annually thereafter, as part of the health history and social history forms.
- Clinical Evaluation: Clinicians privately and verbally screen only when the intake form indicates abuse or they feel someone is at risk or shows signs of FIPV. A clinic volunteer who also works with the local YWCA is called upon as needed.
- Follow-up and Referral: Once the client confirms abuse, the Social Services Coordinator discusses options with the client. Police escorts and Child Protective Services are called if needed. Shelter is found for the client if possible. Telephone numbers and a referral list are given to clients not willing to be transferred to a shelter.

Clinic D: Community Health Center

Location and Population Density: City location serving an urban population
Race/Ethnicity of Population: Mixed African-American and Hispanic
FIPV Activities

- Training: Training is provided annually to all clinic staff. The 45-minute in-service training is not based on a formal curriculum. The material presented focuses primarily on signs and symptoms of FIPV.
- Screening and Intake: FIPV screening is mandatory for all initial patient visits and all prenatal visits. Policy also requires all patients to be screened annually. This screening is performed privately by a medical assistant or social worker with a written questionnaire.
- Clinical Evaluation: Health care providers follow-up affirmed or suspected cases of FIPV with a verbal screening.
- Follow-up and Referral: Clients identified as experiencing abuse are referred to a social worker who counsels client on various options. If the client does not want immediate help, the social worker provides them with information they can refer to at a later time. If the client requests immediate help, a referral to a partner organization is made. Hotline information is provided to clients via discreet business cards.

Clinic E: Family Planning Clinic

Location and Population Density: City location serving an urban population
Race/Ethnicity of Population: Primarily Anglo
FIPV Activities

- Training: No training related to FIPV is provided to the general clinic staff. The clinic employs a Sexual Assault Nurse Examiner (SANE) who has received formal training in FIPV.
- Screening and Intake: All patients are screened at initial intake with a patient history form that includes several questions related to FIPV.
- Clinical Evaluation: If patients indicate FIPV during the written screening, or FIPV is suspected, the health care provider follows-up privately and verbally before the exam. If the health care provider needs help with a case, the Sexual Assault Nurse Examiner is consulted.
- Follow-up and Referral: No formal referral process is currently in place. If a minor is experiencing domestic violence, the authorities are called. The clinic workers provide all other cases with materials and brochures developed specifically for these instances.

Clinic F: County Public Health Department

Location and Population Density: Suburban location serving a rural population
Race/Ethnicity of Population: Primarily Anglo
FIPV Activities

- Training: Staff have the option of viewing a ½-hour video on FIPV when hired. Though staff used to receive annual updates to this training, these updates have not been kept up recently. Staff reported a desire to have additional information and training on the topic of FIPV.
- Screening and Intake: All patients are screened with two questions on the intake screening tool.
- Clinical Evaluation: The clinician uses the Maternal Case Management Assessment Tool to privately and verbally screen during exam if abuse is indicated or suspected. "Shoe cards" are handed out to clients experiencing abuse.
- Follow-up and Referral: In situations of affirmation of abuse during private in-home visits, the nurse talks privately about safety plans and community resources if the patient is ready. If not, the nurse plans further visits with the patient to monitor the situation.

Clinic G: County Public Health Department

Location and Population Density: Suburban location serving a mixed suburban/rural population
Race/Ethnicity of Population: Primarily African-American
FIPV Activities

- Training: No formal training is provided to staff by the County Health Department. Some clinicians have received training from other sources.
- Screening and Intake: All clients fill out a health history form at the intake desk. This form includes a question related to FIPV incidence.
- Clinical Evaluation: If a client responds to the written FIPV screening affirmatively, or if the clinician suspects FIPV, the client is privately and informally screened during the exam.
- Follow-up and Referral: Once abuse is identified, the clinician provides the patient with the name and number of the local shelter or refers the client to the Health Department's Mental Health Division. To protect clients, Health Department staff do not know the location of the local shelter but will facilitate contact with the shelter via the telephone for at-risk clients.

Clinic H: Family Planning Clinic

Location and Population Density: City location serving an urban population
Race/Ethnicity of Population: Mixed Hispanic, Asian and African-American
FIPV Activities

- Training: All clinical and frontline staff receive training created by the clinic's managing organization, based on a national protocol and incorporating state-specific requirements. There are currently two different curricula used: a two-hour course and a one-day course. The curricula include training on medical aspects, policy aspects and social aspects of FIPV. The clinic also tries to send all staff to a national FIPV education program. Clinic training updates typically occur in October for *Domestic Violence Awareness Month*, but may also be conducted more regularly if the clinic sees a spike in its FIPV-patient load.
- Screening and Intake: All patients are screened at intake with a written form at every visit. If the client answers affirmatively to any of the screening questions, a health services specialist follows-up with a verbal screening and alerts the clinician.
- Clinical Evaluation: If a patient has been identified as or is suspected of experiencing abuse, the clinician privately asks about FIPV during the exam. Information regarding FIPV is recorded on a separate form that is not part of the patient's chart. The information on this form is protected and will not be copied.
- Follow-up and Referral: After abuse is confirmed, the clinician informs the client of the clinic's mandatory reporting obligations and the client's privacy rights. The clinician then follows up with the client to facilitate and inform the client of their options and provide referrals and resource information. If the client indicates she/he would like assistance, the clinician refers them to a community FIPV partner and provides resource information related to the organization. If the client would like to make an official report, the clinic coordinates among staff to arrange a time where the client will be safe and the reporting will be kept private.

Clinic I: County Public Health Department

Location and Population Density: City location serving a rural population
Race/Ethnicity of Population: Mixed Anglo and African-American
FIPV Activities

- Training: No training is provided.
- Screening and Intake: All patients fill out an intake form that includes a question regarding FIPV.
- Clinical Evaluation: Informal verbal screening is performed privately by the health care provider if abuse is indicated or suspected. Patients' charts include informal, non-specific notes about FIPV for confidentiality purposes.
- Follow-up and Referral: Patients identified as, or suspected of, experiencing FIPV are given written and verbal information by the clinic director who is also a nurse practitioner. A hotline is offered for counseling and information. Counseling and follow-up are arranged at another center if patient privacy is a concern. At the next visit, the clinician attempts to discern if abuse is continuing by talking with and observing the patient.

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Site Visit Report

For the Project:

A Collaborative Evaluation
of Family and Intimate Partner Violence Prevention Activities
in Selected Title X-supported Family Planning Clinics
Contract Number 282-98-0019,
Task Order 13

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1.0 Introduction

Battelle Centers for Public Health Research and Evaluation is pleased to provide this report to the Office of Population Affairs (OPA) under Contract No. 282-98-0019, Task Order 13, *A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Selected Title X-supported Family Planning Clinics.* The report documents the results of nine site visits to Title X-supported clinics.

The purpose of the site visit activities was to gather information about family and intimate partner violence (FIPV) prevention activities conducted at clinics in nine states. Specifically the objectives were to:

- Assess the extent to which strategies used to implement FIPV integration have been acceptable to program providers, and whether program staff perceive them to be effective and sustainable.
- Identify the impact of FIPV prevention activities on the implementing organizations, and arrive at implications for the program on wider integration of FIPV activities in Title X clinics, including some measures of cost of the program to the clinic.
- Identify specific strategies that the OPA and collaborating agencies can utilize to raise awareness about FIPV and to achieve better integration of FIPV prevention activities into public family planning services.

To gather information to support the objectives, four areas of interest were identified within each objective: clinic policies and protocols, routine screening for FIPV, health care provider and staff training programs, and collaboration with community organizations. For each of the four areas under the objectives, indicators were identified, and these were investigated during the site visits and key informant interviews. Table 1.1 links the objectives, areas of interest, and indicators.

Table 1.1 Linking Indicators to Area of Interest and Evaluation Objectives

Areas of Interest	Indicators
Assess the extent to which strategies used to implement FIPV integration have been acceptable to program providers, and whether program staff perceive them to be effective and sustainable.	
Clinic policies and protocols	• Comprehensiveness • Usability • Perceived usefulness • Source and date of inception • Changes in protocol • Barriers to implementing
Routine screening procedures for family and intimate partner violence	• Timing (initial visit, follow-up) • Criteria for screening • Description • Perceived ease/discomfort of implementing • Methods to ensure confidentiality • Procedures following reported FIPV

Table 1.1 Linking Indicators to Area of Interest and Evaluation Objectives	
Areas of Interest	**Indicators**
Health care provider and staff training programs	• Eligibility for training • Length of training • Curriculum • Frequency of updates • Perceived usefulness by clinicians
Collaboration with community organizations	• Types of organizations • Length and type of collaboration • Involvement in protocol and training • Frequency of communication • Joint activities
Identify the impact of FIPV prevention activities on the implementing organizations, and arrive at implications for the program on wider integration of FIPV activities in Title X clinics, including some measures of cost of program to the clinic.	
Clinic policies and protocols	• Impact on clinic operations • Challenges to implementation • Costs: monetary, resources, time
Routine screening procedures for family and intimate partner violence	• Impact on clinician's activities • Perceived client responsiveness • Costs: monetary, resources, time
Health care provider and staff training programs	• Impact on professional development • Changes in clinician's approach • Costs: monetary, resources, time
Collaboration with community organizations	• Challenges and benefits to collaborating • Costs: monetary, resources, time
Identify specific strategies that the Office of Population Affairs (OPA) and collaborating agencies can utilize to raise awareness about FIPV and to achieve better integration of FIPV prevention activities into public family planning services.	
Clinic policies and protocols	• Unmet needs of clinics and providers • Perceived benefits of FIPV programs • Lessons learned about policies and protocols • Possible dissemination strategies
Routine screening procedures for family and intimate partner violence	• Lessons learned about screening • Unmet needs of providers • Perceived client reaction/receptiveness
Health care provider and staff training programs	• Unmet needs of clinics and providers • Possible dissemination strategies • Lessons learned about training
Collaboration with community organizations	• Lessons learned about collaboration • Methods to identify and work with community organizations

The next section (2.0) of the report explains the methods used to identify the nine participating clinics, conduct the site visits, and analyze the resulting data. Section 3.0 presents the findings from the site visits, including staff interviews and clinic observations. The information is provided by areas of interest. In Section 4.0, the findings are presented by clinic. Clinic or staff names and any other identifying information (e.g., state) have been removed from the discussion of findings. Clinics are identified by type and region. Findings from all data collection activities are summarized in Section 5.0. Appendices attached to the report are noted throughout.

2.0 Methods

The following Section (2.1) provides information about the approach used to identify and contact the sites and schedule the site visits. Following this, the procedures to train site visit staff (2.2) and conduct the site visit (2.3) are explained. Section 2.4 describes management and analysis of the data.

2.1 Contacting Sites and Scheduling Site Visits

Site visits were conducted with nine Title X-supported family planning clinics – one clinic each in 9 of the 10 Department of Health and Human Services (DHHS) regions. These sites were identified using data collected from a survey conducted by Battelle in 2000 and 2001. The survey of more than 800 Title X-supported clinics included information about each clinic's screening practices for FIPV as well as about formal protocols and staff training programs. Data were also available about the number of clients served, the type of clinic (family planning, community health center, public health department), the state in which the clinic was located, the population served (race and ethnicity), and whether the clinic was located in an urban, suburban, or rural setting. Clinics that did not screen for FIPV or have policies about FIPV were eliminated from the sampling frame. From the remaining clinics, a subset was chosen to be approached about participating in the project. Other factors considered in approaching the clinics were:

- FIPV training for staff
- Urban (including suburban) or rural location
- Type of clinic
- Number of clients seen per month

Battelle identified a primary point-of-contact at each site and sent an invitation letter to the sites describing the study and inviting them to participate. A letter from OPA introducing the study and explaining its importance was also included. The invitation letter from Battelle introduced the purpose of the site visits, the general topics to be covered, and the general time frame and length of the visit. Battelle's letter further included contact information for Battelle's Project Director. OPA's letter included agency contact information, should clinics have questions directed to the government (see Appendix A for copies of the invitation letters to the clinics). Battelle's Project Director followed up by telephone one to two weeks after the letters were sent to answer questions and request participation of the site.

Finding clinics to participate in the study was a lengthier and more difficult process than expected, primarily because clinics were too busy to spare clinicians' time or because they were part of a larger organization that had to give permission to participate. This permission was sometimes difficult to obtain within the necessary timeframe. Nevertheless, the final group of clinics that agreed to participate achieved a balance of type of clinic, urban vs. rural location, type of population served, and number of clients served. Before each site visit was made, Battelle advised OPA of the names and addresses of the clinics that had agreed to participate. OPA advised the state grantee and regional program consultant of the clinic participating in their area. A confirmation letter was sent to the site director upon finalization of the details of the site visits. Two days prior to the visit, the site visit leader emailed or telephoned the clinic contact to confirm all details of the visit. The final nine participating sites are described in Table 2.1.

Table 2.1 Description of Final Nine Participating Sites

	Community Health Centers	Public Health Departments	Family Planning/ Reproductive Health Clinics
Urban/Suburban	Region II	Region IV*	Region V Region VII Region IX
Rural	Region I*	Region III Region X Region VI	

*Region I and IV clinics served rural and urban clients.

2.2 Site Visit Team Training

Prior to conduct of site visits, members of the site visit team attended a ½-day training conducted by the Project Director. During the training, procedures for conducting the site visits, using the interview guides and the observation guide, as well as informed consent, post-visit data management, and follow-up with the sites were reviewed. Interview guides and the observation form can be found in Appendices C and D.

2.3 Conducting Site Visits

Eight sites visits were conducted between April and June 2004, with the remaining site visit conducted in November 2004. Each was conducted by a two-person team and lasted between 3 and 6 hours each. At a minimum, interviews were conducted with the clinic director and one clinician. Individuals interviewed at each clinic are more fully described in Section 4. During each site visit, Battelle staff also toured the clinic, walked through the FIPV screening and referral procedures conducted by the site, and obtained relevant documents and materials.

Key informant interviews. The key informant interviews were informal and open-ended but covered the areas within each interview guide. They typically lasted between 30 and 60 minutes each. Clinician interviews were usually shorter because of the clinicians' limited time, with one or two interviews as brief as 20 minutes. Interviews with the Clinic Directors were longer, sometimes as long as two and one-half hours. Each interview was conducted by two Battelle staff, one acting as lead interviewer and the other as note taker. The lead interviewer obtained consent and conducted the interview, and the note taker tape recorded the interviews. Interviews were conducted in private settings.

Archival documentation and materials. During the site visits, Battelle obtained any relevant written documentation available from the clinics relevant to the study objectives including:

- Written FIPV prevention policies and protocols
- Written procedures including screening materials
- Clinician tools such as questions to ask or tools to use with clients
- Client take-away materials such as referral lists, fact sheets, or brochures
- Training materials related to FIPV prevention activities

This activity yielded many documents and other materials. Appendix D lists and describes all of the materials received from the clinics. The materials are described by the clinic's DHHS region

(to identify the source), type, title, producer, intended audience, description or content, and size/style.

Site tour and FIPV walk through. A site tour was conducted by the Clinic Director. The tours included waiting areas, interview rooms, exam rooms, laboratories, restrooms, and any other areas where clients were allowed. Site visitors looked for materials (posters, brochures) related to FIPV, observed the setup (including the privacy) of all rooms available to the client, experienced the intake and screening procedures, and noted the general ambience of the clinic. The information was recorded on the observation form and is included in the site descriptions in Section 4.0.

Post-visit activities. At the conclusion of the site visit, Battelle site visitors met with the Clinic Director to debrief. Site visitors left contact information should any questions arise later or should the clinic staff have additional information to provide. Upon returning to Battelle's office, site visitors debriefed as soon as possible to clarify details and discuss their observations and impressions. Following the debriefing, site visitors prepared a summary of the site visit and sent thank you letters to all clinic representatives who had facilitated the visit.

2.4 Managing Site Visit Data

Key informant interviews. Immediately after the site visits, all notes from the key informant interviews were transcribed and put into the project data files. After review of the transcripts and discussion with OPA, a codebook and coding decision log were developed to identify themes and concepts in the interviews. The short codebook can be found in Appendix F. Interviews were initially coded by two individuals who met to reconcile the differences in coding. Once 90% or better agreement was reached among the coders, all interviews were individually coded. The coding information was housed in a QSR N6© database, a qualitative data analysis software package. Each site was given a unique identification code, based upon their selection criteria, i.e., large/small, urban/rural. Similarly, all individuals mentioned in the data were given an identification code beginning with the site code and followed by a unique identifying code. All other identifying information in the data was stripped and replaced by the identification codes or generic identifiers.

Archival documents and materials. The archival documents and materials obtained during the site visits were catalogued at Battelle and entered into an Excel spreadsheet. Notes regarding the site tour and the FIPV walk-through were transcribed and entered into the project database. Identifying information about the site such as name, state, city, or county were replaced with the words capitalized and in brackets, i.e., {CLINIC}, {STATE}, {CITY}, {COUNTY}.

3.0 Site Visit Results

In this section, results across sites are discussed for each of the following areas: clinic policies and protocols, routine screening for FIPV, health care provider and staff training programs, and collaboration with community organizations.

3.1 Clinic Policies and Protocols

Six of the nine clinics visited had formal policies and procedures established regarding FIPV prevention, although comprehensiveness varied across sites. The three clinics without formalized policies were public health departments – two served rural populations and one served a mixed urban/rural population. Most of the staff interviewed at sites with formal policies and procedures reported that the policies and protocols in place were essential and in the best interest of the patient. Noted as a barrier to following the protocols was the perception that women experiencing FIPV do not answer screening questions truthfully and, even when they do, are often not open to seeking help. Two of the clinics with formal training programs addressed this issue directly as a means to overcome clinician frustration about this situation. Some clinicians also expressed discomfort with verbal screening. Clinicians with more training and experience were less likely to report this discomfort.

FIPV prevention policies and procedures were frequently adapted from regulatory agencies, but several of the clinics developed policies and procedures independently. The three Planned Parenthood clinics visited followed the Planned Parenthood Federation of America's (PPFA) guidelines. Two of these clinics adopted FIPV policies in addition to PPFA's requirements. The public health department in Region VI followed extensive guidelines provided by the state. Both of the community health centers visited (Region I and Region II) developed their policies and procedures with the guidance of either outside consultants (Region I) or independent research by staff at the health centers (Region II). Two clinics were located in mandatory reporting states and noted this as an impetus to developing a protocol to address FIPV. Time was the most frequently reported barrier in implementing policies and procedures, but other obstacles mentioned included language barriers and the inability to ensure patient privacy. It was reported by two of the clinics without any formal established policies that local attitudes toward the topic were a barrier, specifically that FIPV was a taboo topic and/or that the state and county had failed to make FIPV a priority in terms of legislation and resources.

Notable practices include those of the clinic in Region I that uses a computer system, Logician, to screen patients and has all patient records and forms integrated into the computer system. This ensures that no patients are overlooked for screening, referral, or follow-up. It also ensures patient privacy by limiting access to patient records related to FIPV. A password must be used to access the records. A clinician in Region IX mentioned that rapport building and asking patients about FIPV repeatedly were stressed in the clinic's protocols. In Region II, the protocol allowed for some flexibility in verbal screening that the staff felt was very important because the clinician's best judgment dictated the timing and style of the screening.

Table 3.1a Family and Intimate Partner Violence Clinic Policies and Protocols – Urban Clinics

Evaluation Indicators	Region II	Region IV	Region V	Region VII	Region IX
Comprehensiveness	The agency has extensive policies regarding FIPV screening. The protocols include both written and verbal screening of each patient. However, clinicians do not report following a universal "one size fits all" screening process for all patients, and instead describe a situation where they have the flexibility to adjust the screening process as needed for each individual.	Facility has no formal policies or procedures related to FIPV. They will report if the victim is a minor.	The clinic is required to follow Planned Parenthood's policies at a minimum and has opted to exceed those requirements with a more comprehensive FIPV screening program.	All patients are screened at intake with a health history form that has several questions regarding FIPV. Verbal screening is only done with patients reporting violence on the intake form, or if the nurse suspects violence based on nonverbal cues (bruising, shaking, etc.).	Have formal policies and procedures established. The policies and procedures are somewhat complicated due to the state's reporting requirements.
Usability	Both the director and the clinician report a situation where FIPV screening has been fully integrated into the system without overburdening caregivers and patients. By not establishing a rigid protocol that clinicians must follow during verbal screening, physicians are empowered to use their best judgment in the approach they take to screening.	Not applicable	All clinicians reported being comfortable with the current FIPV screening policies and procedures.	Written tool was described as an easy way to gain background information about a patient. Clinician mentioned feeling uncomfortable about bringing up the topic with patients.	Policy and protocols are easy to follow, and when any issues come up, they are quickly resolved.
Perceived usefulness	Clinician and director viewed FIPV screening as essential and useful in detecting cases.	Not applicable	Staff expressed concern about FIPV and sexual assault and felt the policies and protocols in place were essential and in the best interest of the patient. At the same time, clinicians noted that many FIPV cases do not answer truthfully to screening questions, and even when they do, are often not open to seeking help.	Staff said that the majority of cases do not indicate violence on the written form, and those that do are indicating past abuse. Verbal screening was seen as being more useful. Building rapport with the patient as well as repetition were both mentioned as key elements of verbal screening.	Viewed as essential in ensuring all clients are given an opportunity to seek help if they need it.
Source and date of inception	Senior team management developed policy and protocols based upon focus group feedback and a review of relevant research.	Not applicable	Not discussed	Follow PPFA policies and protocols.	Director was unsure of the source and date of inception.

Table 3.1a Family and Intimate Partner Violence Clinic Policies and Protocols – Urban Clinics

Evaluation Indicators	Region II	Region IV	Region V	Region VII	Region IX
Changes in protocol	No changes noted in data collected.	Not applicable	Not discussed.	Not discussed.	Changes are made on an ongoing basis by both the clinic director and PPFA based upon the latest research.
Barriers to implementing	No barriers noted.	State and county have not made FIPV a priority in terms of legislation or resources.	None mentioned.	In the past, language barriers have been an issue, but recently the clinic has been able to add some Spanish-speaking members to the staff to address this problem. Not all staff have received formal training on FIPV.	The clinic director reported that finding the time to train staff has been the greatest challenge to implementing FIPV policies and protocols. It was mentioned that the clinic must either close or run with a minimal staff during trainings.

Table 3.1b Family and Intimate Partner Violence Clinic Policies and Protocols – Rural Clinics

Evaluation Indicators	Region I	Region III	Region VI	Region X
Comprehensiveness	The clinic has developed formal policies and protocols with regard to FIPV screening and referral. They developed these with the assistance of an attorney from the local shelter.	No formal policies or procedures in place.	Clinic follows comprehensive guidelines established by state, but has no site-specific policies or protocols.	No formal policies or protocols in place.
Usability	Those interviewed reported that over the past couple of years the screening process has evolved to become user-friendly for both staff and patients. Use of the computer program Logician has made screening easier as it generates follow-up questions based on how the previous question was answered. The computer system also ensures consistent screening and eliminates the possibility of the provider forgetting this part of the exam.	Not applicable	Staff report that the protocol is user-friendly but also state that a new form currently being piloted is more in-depth and easier for the patient to understand.	Staff expressed neither a desire to have a more formalized program nor any discomfort with current policies and protocols.
Perceived usefulness	Staff admitted being resistant at first to adopting the new FIPV screening protocol but report they now see a real value in screening all patients. Clinicians now describe the process as rewarding.	Not applicable	Perceived as useful by staff.	Mixed feelings about the effectiveness of screening. One clinician said she had a way of getting clients to open up over time. Other clinicians felt that most victims deny FIPV, making screening ineffective.
Source and date of inception	Protocols were developed by clinic staff with assistance from the local crisis center and put into place October 2000.	Not applicable	Follow state's Title X policies and protocols.	Not applicable
Changes in protocol	Minor changes have been made to the protocol based on feedback from staff and patients. Changes included switching to a computer-based patient chart system and altering terminology used (such as adopting the term "relationship abuse" instead of domestic violence).	Not applicable	Have always followed state's protocol/requirements	Not applicable
Barriers to implementing	Time rather than cost was reported to be the greatest barrier to implementing FIPV screening.	Not applicable	A large, sparsely populated geographic area is served by the clinic, making it more difficult for victims of FIPV to return to the clinic for further assistance. Some rooms are not sound-proof, making it more difficult to ensure patient privacy.	Lack of resources were mentioned by some respondents as a barrier. It was also stated that the topic of FIPV remains taboo in the area.

3.2 Routine Screening Procedures for Family and Intimate Partner Violence

All of the sites visited reported following similar FIPV screening routines. Each site reported screening patients at intake with written question(s) about FIPV. The written screening usually consisted of 1 to 3 questions, although two of the clinics used longer, more sensitive instruments for screening. Follow-up verbal screening was approached differently according to each clinic's policies and procedures. Most clinics reported verbally screening patients when the patient indicates abuse on the written intake form or when the clinician suspects abuse based upon signs, symptoms, and the clinician's intuition. Clinics reported screening all new patients and performing screening annually thereafter.

Verbal screening. As mentioned earlier, verbal screening varied slightly among sites. Some of the clinics had a staff member, such as a health services specialist or a social worker, assigned to verbally screen all patients indicating violence on the intake form before the patient sees their caregiver. However, at the majority of the clinics, the caregiver was responsible for verbally screening the patient. A few of the clinicians interviewed reported feeling uncomfortable with the verbal screening process. Training and experience were reported to ease these anxieties. Region I uses a system called *Logician*, a program where written screening is conducted via a computer, ensuring patient privacy because access to the files is limited. The program then alerts the clinician about all areas (including FIPV) that require follow-up. In-home providers in Regions VI and IX felt that their additional contact with patients in the patient's home was particularly important for identifying FIPV. These clinicians can observe family dynamics and often see a client for more than ½ hour every month for a year or more.

Confidentiality. In order to ensure patients' privacy, most of the clinics visited allow only the patient in the exam room, but some clinics reported bending this rule with insistent partners/patients. This was particularly noted in Region III. Clinics reporting that they occasionally allow partners in the exam room have developed some creative ways to screen patients alone under these circumstances, such as talking with the patient in the ladies' restroom or scheduling additional visits with the patient, providing an opportunity to develop a rapport with the patient. Several clinics also allow partners in the exam room during prenatal exams.

With suspected and reported cases of FIPV, most of the clinics took additional steps to ensure patient privacy. Some of the clinics reported making it a point to hand out referral information via discreet business cards that do not have direct references to the organizations. Some clinics reported storing abuse information about patients in a separate locked file to ensure that accidental revealing of FIPV information does not occur. Another action taken by some clinics was to cease mailing medical bills and receipts to the patient's house. Other clinics do not record FIPV information in medical charts or do so using codes or non-specific language.

Procedures following reported FIPV. FIPV was treated differently at each clinic, with some clinics taking a more proactive and involved role than others. Four of the clinics visited have the patient meet with a staff member trained to assess the patient's immediate safety and counsel the client on various options. Three of the sites visited did not provide counseling, and instead relied on providing patients with a hotline number and the name of an organization that could assist them. Urban clinics were more likely than rural clinics to have a staff member counsel the patient.

Table 3.2a Routine Screening Procedures for Family and Intimate Partner Violence – Urban Clinics

Indicators	Region II	Region IV	Region V	Region VII	Region IX
Timing	FIPV screening is mandatory for all initial patient visits and initial prenatal visits. Policy also requires all patients to be screened at least once a year.	All clients fill out a health history form at the intake desk that includes a question related to domestic violence. If the person answers yes to this question or if the health care provider suspects FIPV they will verbally screen the client during the exam.	Screening occurs at intake as part of health history forms and social history forms. Clinicians do not screen unless they feel someone is at risk or shows signs of FIPV (bruising).	All patients are screened at intake with a patient history form that includes several questions related to FIPV. If the patient indicates domestic violence on the form, the nurse practitioner will probe verbally before the exam. Likewise, if the nurse practitioner suspects FIPV, the patient will be verbally screened.	All patients are screened at intake as part of every visit. If the client answers affirmatively to any of the screening questions, a health services specialist will follow-up with a verbal screening and alert the attending physician or nurse practitioner. The patient is then asked about FIPV during their exam.
Criteria for screening	Screening is performed with all patients as part of their initial clinic visit and annually thereafter. In addition all initial prenatal visits include screening, regardless of whether the patient has been screened within the past year.	Nurses verbally screen clients who admit to domestic violence on the intake form or those clients they suspect are victims of FIPV.	Screening performed on all patients as part of their initial visit and annually thereafter.	All new patients are screened when they fill out initial paperwork. Also all suspected cases are screened by the nurse practitioner.	All patients are screened with a written health history form at all visits. Only patients who indicate abuse are verbally screened.
Description	All new clients are privately screened at intake by a medical assistant or social worker with a written questionnaire, and the physician follows up with a verbal screening.	No formal screening protocol exists. If nurse suspects or patient admits to being in an abusive situation, the nurse may ask some questions and provide the client with some basic materials.	Written screening as part of intake and an informal discussion about relationships with nurse practitioner. Further verbal questioning may occur if the patient presents with signs or symptoms of FIPV.	Written screening at intake administered to all patients and verbal screening of patients that have either indicated FIPV or are suspected cases.	Screening begins with the general health history form, which includes questions related to FIPV. If the client answers affirmatively to any of the screening questions, a health services specialist will follow up with a verbal screening and alert the attending physician or nurse practitioner.
Perceived ease/discomfort of implementing	Neither the director nor the physician mentioned any difficulties in implementing FIPV screening. Incorporation of screening occurred smoothly.	Clinicians report frustration when the patients deny FIPV with obvious signs of abuse.	No difficulties reported.	Sexual Assault Nurse Examiners (SANE) and Spanish-speaking nurse practitioners have made screening easier. One employee did express feeling apprehensive about approaching the subject of FIPV with patients.	Some staff do not feel comfortable with FIPV cases. In addition the reporting requirements for this particular state are quite complicated, which is reported to be a bit overwhelming for staff. Training was reported to help boost staff comfort level. When the program was first initiated in response to mandatory reporting laws, staff

Table 3.2a Routine Screening Procedures for Family and Intimate Partner Violence – Urban Clinics

Indicators	Region II	Region IV	Region V	Region VII	Region IX
					were concerned about the effect on patients but, to date, they have not observed any ill effects.
Methods to ensure confidentiality	Patients screened alone in private area. Hotline information provided via discreet business cards instead of bulky brochures.	The facility makes a point to screen patients alone.	Only patients allowed in exam rooms with the exception of prenatal visits.	Patient is seen alone. Parents/partners are not allowed in the exam room unless the patient requests it, and only after the nurse practitioner has had the chance to talk with the patient alone.	No one can accompany a patient into an exam room until the patient has been screened alone with the caregiver. Also information regarding FIPV is recorded on a separate form that is not part of the chart. The information on this form is protected and will not necessarily be copied.
Procedures following reported FIPV	Clients are referred to a social worker who counsels client on various options. If client does not want help, the social worker informs the client they can always come to the clinic for assistance in the future and provides them with information in case they change their mind. If the client is willing to seek help, a referral to a partner organization is made.	Health care provider either provides the patient with the name and number of a local shelter or refers the client to the health department's Mental Health Division.	The Social Services Coordinator speaks with the client. Police escorts and CPS (Child Protective Services) are called if needed. Shelter is found for the client if possible. At the very least, telephone numbers and a referral list are given to the client. The Social Services Coordinator fills out a referral form.	No formal referral process is currently in place. If a minor is experiencing domestic violence, then the authorities are called. The clinic workers provide all other cases with materials and brochures developed specifically for these instances.	The clinician informs the client of the obligation for mandatory reporting and their privacy rights. Afterward the clinician follows up with the client to facilitate and inform the client of their options and provide referrals and resource information. If the client indicates she/he would like assistance, the clinician refers them to Women Escaping A Violent Environment (WEAVE) and provides resource information related to the organization. If the client would like to make an official report, the clinic coordinates among staff to arrange a time where the client will be safe and the reporting will be kept private.

Table 3.2b Routine Screening Procedures for Family and Intimate Partner Violence – Rural Clinics

Evaluation Indicators	Region I	Region III	Region VI	Region X
Timing	Patients are screened with a written questionnaire when they are taken to the exam room by the medical assistant, before they are seen by the clinician. Verbal screening is performed by the clinician during the exam in cases where the patient has either indicated abuse or the clinician suspects abuse.	Written screening at intake, with verbal screening during the exam if the patient has indicated a violent situation or if abuse is suspected.	Written screening takes place at intake as part of the state health history form. Nurse then verbally reviews the form with the patient in the exam room. Patients complete this form annually. Also all prenatal and postpartum visits include verbal screening during each visit.	Written screening is done at intake. Clinician verbally screens during exam if patient indicates abuse or if clinician suspects abuse.
Criteria for screening	All patients are screened at each visit unless the privacy and safety of the patient cannot be ensured. Also, screening may be eliminated if time is limited or if more immediate health matters need to be addressed.	All patients are asked a question on intake form. Verbal screening is performed by the physician or nurse they if suspect abuse based on symptoms (bruising) or if the patient indicates abuse on the written form.	All male and female patients are screened with the exception of young children who are coming in for immunizations.	Written screening for all patients. Use Maternal Case Management Assessment Tool to identify suspected cases of FIPV for follow-up with verbal screening.
Description	Medical assistant goes through initial questions and pre-screens for various topics in a patient care room. Screening questions about FIPV are included. These questions are only asked if patient is seen alone. Medical assistant takes notes and shares these with the physician assistant/clinician. The clinician further screens if there is an indication that the patient is experiencing FIPV.	One FIPV question on written screening tool that women complete. No formal verbal screening, although public health nurse will screen and physician will ask questions if patient seems at risk.	Screening of FIPV begins with completion of an intake form that includes questions related to domestic violence. These questions are integrated in the subjective objective assessment planning (SOAP) general medical screening guidelines. When the patient then meets with the nurse practitioner, she/he is asked to talk about any problems she may have. Concurrently, the nurse practitioner also pays attention to any signs of physical abuse the patient may show. If the patient is reluctant to reveal any information or provide any information, the nurse practitioner asks specifically about violence.	Two FIPV questions on the intake screener for the clinic. The prenatal program's referral form also includes the referring agencies' assessment of FIPV. The clinic's in-home checklist has several sections to complete after the first in-home visit that are applicable to FIPV. Clinician talks to patient and looks for other signs of abuse.
Perceived ease/discomfort of implementing	Staff reported feeling comfortable with screening patients for FIPV now, but did report feeling apprehensive at first. Practice, training, and introduction of Logician software were all cited as helping staff become more comfortable with the	Clinic has experienced several incidents where a partner insisted on accompanying patient into exam room. Some of these escalated to the point where a gun was aimed at staff. To avoid such dangerous situations, staff	Staff comfortable with the screening method.	No difficulties reported

Table 3.2b Routine Screening Procedures for Family and Intimate Partner Violence – Rural Clinics

Evaluation Indicators	Region I	Region III	Region VI	Region X
	process.	may not examine the woman alone if a partner is insistent on being present, and thus may not verbally screen for FIPV.		
Methods to ensure confidentiality	Only screen when client is alone. When the patient's chart includes sensitive material, patient and doctor often establish a code word to protect sensitive information. Also any forms documenting violence are kept in a separate, locked cabinet apart from the patient's medical file. The computer patient record system limits and controls access to patient health data. Once a patient reports FIPV, no charges from the office are billed to the patient's home address.	If the patient is accompanied by a partner, the clinician attempts to persuade him to wait in another room, leaving the patient free to talk to the provider in private in the exam room. Informal, non-specific notes are written in patient's chart in order to keep information confidential. Sometimes patients choose to receive care in a nearby town where they are less likely to see someone they know.	Clinic tries to keep partners and parents in the waiting area. In cases where a partner/parent is present in the exam room and FIPV is suspected, the nurse either transfers the patient to another private exam area or asks the partner/parent to step outside the room.	Patients are screened alone. Clinic uses shoe cards (cards small enough to fit in woman's shoe, typically 11/2"' by 3") with referral information.
Procedures following reported FIPV	For patients identified as having experienced FIPV, clinician arranges a meeting with the social worker. If the social worker is able to see the patient immediately, as is preferred, the social worker performs a safety assessment to ensure it is safe for the patient to return home and makes referrals – usually to "A Safe Place". If this is not possible, the clinician performs the safety assessment, provides referral numbers, and makes an appointment for the patient to see the social worker. The clinician obtains contact information from the patient (i.e., when and where to call) and shares this information with the social worker, who follows up as needed with the patient.	Patient is given written and verbal information. A hotline is offered for counseling and information. Counseling is offered at another center. At the next visit, the clinician attempts to discern if abuse is continuing by talking with and observing the patient.	Once a patient is identified as experiencing FIPV, the nurse manager meets with the patient in a private office and offers counseling and referral information. Usually the patient is presented with options about what to do and where to go when domestic violence occurs. Follow-up occurs when the patient's situation is deemed very serious and the nurse is concerned about the patient's well-being.	Referrals after a family planning visit were not described. Not able to interview the clinician who was unexpectedly out of the office. For the in-home visits, if the situation is private, the nurse talks about safety plans and community resources if the patient is ready. If not, the nurse plans further visits with the patient to monitor the situation.

3.3 Health Care Provider and Staff Training Programs

The FIPV training programs varied greatly among the clinics visited, with some providing little or no training on the topic and others requiring employees to attend annual conferences on the subject. Clinics located in urban areas tended to provide employees with more training than those located in rural areas (see Table 3.3a and Table 3.3b). However, it is an oversimplification to attribute training (or lack thereof) to only rural/urban differences. Urban clinics tended to be larger, better funded and have more training resource readily available. Three of the rural clinics were also public health departments, agencies with many additional responsibilities. Two of the public health departments also mentioned recent budget cuts that required reduction of staff and services. For smaller agencies, the Clinic Director's interest in FIPV appears to play a role in determining the amount of time, energy, and resources the clinic is likely to invest in employee FIPV training programs.

Urban clinics. Most of the urban clinics we visited required employees to attend annual training, and three extended this requirement to all staff members that encounter patients, including receptionists. Many of the urban clinics had specialized staff such as social workers, health educators, and Sexual Assault Nurse Examiners who have received additional and more specialized training. Training was provided through a variety of sources (e.g., in-service, parent agency, community-based organizations). All of the clinics' training approaches were unique, with few overlapping elements. Clinic staff reported that training was useful both in the work setting and in their personal lives. The length of training ranged from 1 to 2 hour in-services to half-day and full-day training. The clinic in Region II developed its own FIPV training program, based on research in the area and focus groups with patients and providers. The Region IX clinic's training program came from the managing organization in direct response to state mandatory reporting laws.

Rural clinics. Of the four rural clinics visited, one had no FIPV training whatsoever and one site's training comprised a video for new employees. While it is clear that the rural clinics visited have less comprehensive training programs compared to clinics located in urban settings, the reasons for this are multifaceted and vary regionally. For example, staff interviewed at rural clinics in the Southwest and West (Regions VI and X) expressed a desire for more training related to FIPV, but identified isolation and lack of resources as barriers. Staff in Region IV had attended conferences with FIPV prevention sessions for clinicians but found these to be of limited use to them. In contrast, two other rural clinics reported that FIPV training was not valued by their organizations, and the relative absence of FIPV in the community (compared to other concerns) were the primary reasons the clinic does not provide FIPV training. The clinic visited in Region I perceived FIPV training as useful and developed a formal in-service training program with the help of a local organization.

Table 3.3a Health Care Provider and Staff Training Programs by Region – Urban Clinics

Evaluation Indicators	Region II	Region IV	Region V	Region VII	Region IX
Training provided	Training is provided to all clinic employees (receptionists, lab technicians, nurses, social workers, doctors, etc.).	No training is provided to staff. Some staff have been to conferences and attended sessions on the issue.	Clinic provides all staff educational opportunities to attend conferences and lectures on topics related to FIPV. Clinicians can attend both state-sponsored training and local training. Some nurses also reported they had attended a conference hosted by DHHS on the topic of domestic violence.	No training related to FIPV is provided to staff with the exception of the Sexual Assault Nurse Examiner.	Clinic has training program created by their managing organization, based on PPFA's protocol and incorporating state-specific requirements. Clinic also tries to send all staff to PPFA's FIPV education program.
Eligibility for training	All employees are required to participate in annual training.	No training provided.	All staff members are invited to attend sessions.	Only Sexual Assault Nurse Examiner receives formal training.	All clinical and frontline staff receive training.
Length of training	Training takes approximately 45 minutes.	No training provided.	Training provided by the YWCA takes approximately 50 to 60 hours.	Not discussed. {NOTE: SANE training varies by program but typically includes 40+ hours of education, clinic hours, continuing education, and competency testing.}	There are two different curricula: a two-hour and a one-day format.
Curriculum	Annual in-service training is not based on a formal curriculum. Material presented focuses primarily on signs and symptoms.	No training provided.	YWCA curriculum includes onsite training, role playing, general education, and lectures by guest speakers.	No training provided	Includes training on medical aspects, policy aspects, and social aspects of FIPV.
Frequency of updates	Updates annually for all staff members with the exception of social workers who receive updates bi-annually.	No training provided.	No regular updates.	Sexual Assault Nurse Examiner receives training updates at least once per year.	There is no set schedule for training updates. Typically updates are provided in October but may also be done at some other time if a clinic identifies a high rate of FIPV or if there are a large number of new staff.
Perceived usefulness by clinicians	Well received by clinicians.	No training provided. Staff noted that conference sessions attended covered little material and did not help much.	Staff spoke positively about training received but expressed a desire for additional continuing education opportunities.	Clinicians reported a desire to have FIPV training and felt it would help them perform their duties more effectively.	Perceived as useful.

Table 3.3b Health Care Provider and Staff Training Programs by Region – Rural Clinics

Evaluation Indicators	Region I	Region III	Region VI	Region X
Training provided	Formal annual training provided at the clinic includes reviewing protocols and reporting laws. A guest speaker from A Safe Place also gives a presentation about domestic violence at each annual training. In addition, staff members receive updates on FIPV issues in the form of 'lunch and learn' meetings.	None	Training is provided annually by the state. In addition, the clinic provides updates as part of staff meetings.	Staff receive training through a video when hired. Optional for some staff.
Eligibility for training	All staff receive training, including front office staff.	Not applicable	All clinicians receive training	All Special Supplemental Nutrition Program for Women, Infants and Children (WIC) counselors are required to watch the video, others may choose to view as well.
Length of training	Incorporated into part of an all-day annual training. Updates last approximately one hour and are conducted four times per year.	Not applicable	Annual training typically lasts 1 to 2 days.	Video is ½-hour long.
Curriculum	Formal curriculum adopted from standard training material.	Not applicable	Curriculum developed by the state and in accordance with federal guidelines.	Not applicable
Frequency of updates	Updates provided quarterly through 'lunch-and-learn' meetings and newsletters.	Not applicable	Updates reported to be provided once a month at staff meetings.	Annual updates formerly but not kept up lately.
Perceived usefulness by clinicians	Clinicians perceive training as useful and request worst-case scenario role plays at annual training.	Not applicable	Staff were positive about material covered during training but frustrated by distance they needed to travel in order to attend. Expense and time demand associated with traveling to the training viewed as limiting staff training opportunities.	Staff felt current training needed to be reviewed and revised. Reported a desire to have additional information and training on the topic of FIPV.

3.4 Collaboration with Community Organizations

All of the clinics visited collaborated with local community organizations and had an FIPV referral agency they worked with on an ongoing basis. Almost one-half of the sites utilized community organizations to help provide clinic staff training, and one of the sites utilized a community organization to assist with development of their FIPV policies. Three of the clinics participated in violence prevention coalitions with organizations in their community.

However, it should be noted that while urban and rural clinics collaborated with other organizations, the nature of these relationships differed greatly between these settings. In urban settings, clinics often teamed with local community-based organizations such as the YWCA and Women Escaping A Violent Environment (WEAVE). Most of the urban clinics had staff training programs that community organizations developed, delivered, and/or participated in, whereas many of the rural clinics did not have staff training programs. Typically, clinics located in urban settings had more organizations with which they collaborated and were able to work with organizations that focused more directly on FIPV than was true of those clinics in rural settings. The Region IX clinic (urban) worked with Hispanic and Asian community organizations because staff served this population. The Region II clinic (also urban) worked with a coalition that included police, other health care agencies, churches, and violence prevention organizations.

In rural settings, clinics worked more closely with the local hospitals, local sheriff's departments, local churches, and local safe houses. The Region III clinic had a completely different approach – collaborating with local businesses and the local college to raise awareness about FIPV while seeking funds, space, and other resources to implement prevention programs. For a summary of each region's community collaborations, please refer to Tables 3.4a and 3.4b.

Table 3.4a Collaboration with Community Organizations by Region – Urban Clinics

Evaluation Indicator	Region II	Region IV	Region V	Region VII	Region IX
Types of organizations	Community organizations representing a variety of causes including safe houses.	Clinic has no collaborative efforts with regard to FIPV prevention and assistance. Hospital system and sheriff's department in a neighboring county are collaborators. Also the clinic works with organizations whose interests are prenatal and pediatric care.	The YWCA, a local association outreach program, a substance abuse center, a behavioral health clinic, and a rape crisis center are collaborators.	Two local crisis centers, local schools, some local PTAs, National Organization for Women, and state chapter of the Religious Leaders for Reproductive Choice are collaborators.	Women Escaping a Violent Environment (WEAVE), teen program run through youth center, and some organizations that deal with Hispanic and Asian populations are collaborators.
Length and type of collaboration	Long term, ongoing collaborations	Ongoing collaborations, but not FIPV related.	This clinic is within walking distance of a local YWCA that offers a wide range of services to assist victims of FIPV and sexual assault. The YWCA houses both a rape crisis center and a shelter, provides counseling, assists people in locating shelters and halfway houses, and helps people with children apply for Medicaid. Not only does the clinic refer patients to this agency, but it also contracts with the YWCA to provide employee FIPV training. The clinic works with the local association on cases where problems are suspected in the home. The association sends a social worker to the home to check up on and provide resources to the person/family. Referral is made without patient consent. Additional types of referrals include substance abuse center, behavioral health clinic, and rape crisis center.	Clinic refers FIPV cases to two different local crisis centers that the clinic educator communicates with on a regular basis. Also the clinic's educator has done educational presentations for some of the local schools as well as some PTA chapters on various topics, including FIPV. Brochures are mailed to schools advertising the educational programs offered by the clinic. Schools/educators can then choose which programs, if any, they would like to have presented to their students. The clinic also works with other organizations to increase community awareness of FIPV.	Staff have worked closely with WEAVE for many years. WEAVE has served both as a resource for the clinic and as a referral agency. In terms of the youth-focused organizations, as well as the Hispanic and Asian community organizations, the clinic has not worked with these organizations as long or as closely.

Table 3.4a Collaboration with Community Organizations by Region – Urban Clinics

Evaluation Indicator	Region II	Region IV	Region V	Region VII	Region IX
Involvement in protocol development and training	Victim assistance agency assists the clinic with its annual training program as well as with patient referrals.	Not applicable; the facility does not have formal FIPV protocols or training.	YWCA provides educational lectures to the staff on domestic violence.	Clinic offers training to the collaborating organizations related to FIPV. Protocol was developed by the Planned Parenthood consortium in response to state laws.	WEAVE used to train staff at the clinic. However, after receiving a grant, the clinic went back and retrained WEAVE staff. The clinic's educational staff have worked for WEAVE's 24-hour hotline.
Frequency of communication	Communication between the clinic and community organizations occurs on a regular basis.	Communication is usually related to a particular case.	Communication occurs on a regular basis.	Communication is regular and ongoing.	Clinic communicates with WEAVE on a regular basis, but less often with the other organizations.
Joint activities	Include neighborhood meetings and coalitions, employee training programs, and patient education. The victim's assistance agency provides the community health center with posters and brochures and helpline telephone numbers.	Hospital system and public health department refer clients to one another. The sheriff's department assists with displaced children and often attends local health fairs.	Clinic and YWCA make mutual referrals.	Clinic works with many organizations on a number of activities to raise awareness about FIPV.	WEAVE and the clinic collaborate to provide training to all staff.

Table 3.4b Collaboration with Community Organizations by Region – Rural Clinics				
Evaluation Indicators	**Region I**	**Region III**	**Region VI**	**Region X**
Types of organizations	A Shelter (A Safe Place) and the [state] Coalition Against Domestic and Sexual Violence are collaborators.	In addition to one FIPV referral agency, the clinic collaborates with other types of organizations (businesses, senior citizens groups, unions) on a variety of health issues, including FIPV.	A local hospital, the local schools, a nearby safe house, and the local churches are collaborators.	The health clinic works with two local organizations. One deals primarily with empowering women to stand up for themselves, and the other is a family support group that helps with children as well. In addition, the clinic works with two different safe houses.
Length and type of collaboration	The safe house is located across the street. A representative from the safe house meets with clients who have expressed a desire for such help. The coalition meets and discusses standards in health care and provides training on the issue of FIPV.	Collaboration to hold health fairs and conduct health education talks.	Some patients are referred to the local hospital for exams and treatment not offered at the clinic. Clinic staff visit several local schools and provide in-service education on sexual assault. Brochures are provided to the students on the topics covered. The clinic and the safe house refer clients to one another for services. It was also mentioned that many of the local churches provide food and other essentials to women who are trying to escape FIPV.	These are all organizations to which the clinic refers patients.
Involvement in protocol development and training	Staff from the safe house helped the clinic develop its FIPV screening protocol. Safe house also sends staff members to the clinic's annual training on FIPV. Social workers receive additional training from the coalition.	Not applicable	Not applicable. Protocol and training provided by the state.	None
Frequency of communication	The safe house and the clinic communicate on a regular basis. The coalition meets formally every quarter. However, it is reported that e-mail communication occurs frequently.	The communication is ongoing and depends on current activities.	Not discussed	As needed
Joint activities		Clinic Director worked with college to give FIPV talk.		

4.0 Site Summaries

The following section describes each of the sites visited in terms of the four areas of interest. One clinic from each DHHS regions (except Region VIII) was visited. Two-person site visit teams interviewed Clinic Directors and staff, toured the clinic, and collected materials and documents related to FIPV.

Region I: Community Health Center

Site description. The Region I clinic is a community health center with two locations in a small city serving a rural population. The facility has six exam rooms and an on-site laboratory. Family planning is the primary focus of the clinic but additional services offered include: primary care, prenatal care, STD/HIV testing, nutrition, social work, health education and outreach, medication, asthma management, diabetes management, dental services, and WIC services. Between the two sites there are approximately 35 full-time employees and 35 part-time employees, including four physicians, two physician assistants, a nurse practitioner, six registered nurses (RNs), three social workers, two registered dietitians, and a health educator. On average the clinic provides care to approximately 90 to 100 patients per week. During the site visit, the clinic director and one clinician were interviewed.

FIPV-related activities. The clinic has established formal policies and protocols regarding FIPV screening. The clinic utilized a legal expert, as well as staff from a women's shelter, to assist with development of these policies. Outlined in the protocol are procedures for screening and referring patients. Current procedures are such that all new clients are privately screened at intake by a medical assistant with a written questionnaire. If there is any indication of FIPV, the clinician further screens the patient verbally. The protocol also requires that all subsequent visits to the clinic include screening unless the patient is not alone, time is limited, or more immediate health matters need to be attended to. Counseling and referrals are to be given to all persons reporting FIPV.

In addition to developing a formal protocol, the clinic has also taken steps to make sure FIPV resources are available to clients. Every room had posters on the walls that included referral information and had tear away telephone numbers a client could take with them. Brochures were also present in all of these areas, with the exception of the restrooms. Exam rooms also had a binder with resource information that further served as a reference for clinicians.

Developing an effective and comprehensive approach to FIPV prevention includes employee education and staff development. Each year all employees are required to attend FIPV training, and updates are provided throughout the year to keep employees informed on the issue. Training materials and curriculum have been developed in collaboration with the same local victim's assistance agency that the clinic uses for FIPV referrals. Role playing has been incorporated into the training process as well. Staff was initially skeptical about the FIPV training but now is interested in additional training in the area.

Even though this clinic is located in a rural setting, it has nevertheless been able to network effectively with other organizations. One organization the clinic has used both as a resource and for referrals is *A Safe Place*. This organization helps victims find shelters and has provided

training on FIPV to the clinic staff. When the clinic was developing its FIPV resources, it was able to seek expert advice from persons associated with this group. While the clinic works most closely with *A Safe Place*, other groups the clinic works with include: the state's Coalition Against Domestic Violence, local obstetricians and gynecologists, local police, the Chamber of Commerce, and the local hospital.

Table 4.1 Summary of Region I Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	The clinic has developed formal policies and protocols for the FIPV screening and referral processes. These were developed with the assistance of an attorney from the shelter.
Usability	Those interviewed reported that over the past couple of years the screening process has evolved to become user-friendly for both staff and patients. Use of the computer program Logician has made screening easier as it generates follow-up questions based on how the previous question was answered. The computer system also ensures consistent screening and eliminates the possibility of the provider neglecting this part of the exam.
Perceived usefulness	Staff admitted being resistant at first to adopting the new FIPV screening protocol but report they now see a real value in screening all patients. Clinicians now describe the process as rewarding.
Source and date of inception	Protocols were developed by clinic staff with the assistance of the local crisis center and put into place October 2000.
Changes in protocol	Minor changes have been made to the protocol based on feedback from staff and patients. Changes included switching to a computer-based patient chart system and altering terminology used (such as adopting the term "relationship abuse" instead of "domestic violence").
Barriers to implementing	Time rather than cost was reported to be the greatest barrier to implementing FIPV screening.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	Patients are screened using a written questionnaire when they are first taken to the exam room by the medical assistant, before being seen by the clinician. Verbal screening is performed by the clinician during the exam in cases where the patient has either indicated abuse or the clinician suspects abuse.
Criteria for screening	All patients are screened at each visit unless the privacy and safety of the patient cannot be ensured. Also, screening may be eliminated if time is limited or if more immediate health matters need to be addressed.
Description	The medical assistant goes through initial questions and pre-screens for various topics in a patient care room. Screening questions about FIPV are included. These questions are asked only if patient is seen alone. The medical assistant takes notes and shares them with the clinician. The clinician further screens if there is an indication that this patient is experiencing FIPV.
Perceived ease/discomfort of implementing	Staff reported now feeling comfortable with screening patients for FIPV, despite being apprehensive at first. Practice, training, and introduction of Logician software were all cited as helping staff become more comfortable with the process. Some frustration was expressed with the amount of time it can take to reach resources via telephone.
Methods to ensure confidentiality	FIPV screening is done only when client is alone. When patient's chart includes sensitive material often patient and doctor establish a code word to protect sensitive information. Also any forms documenting violence are kept in a separate, locked cabinet apart from the patient's medical file. The computer patient record system limits and controls access to patient health data. Once a patient reports FIPV, no charges from the office are billed to the home address.
Procedures following reported FIPV	If a patient is identified as experiencing FIPV, the clinician arranges for her to meet with the social worker. If the social worker is able to see the patient immediately, as is preferred, the social worker performs a safety assessment to ensure the patient can return home and makes referrals according to the patient's specific needs and situation. If this is not possible, the clinician does the safety assessment, provides the patient with referral numbers, and makes an appointment for the patient to meet with the social worker. The clinician obtains contact information from the patient (i.e., when and where to call) and passes this information on to the social worker, who then follows up as needed with the patient.
Health Care Provider and Staff Training Programs	
Training provided	Formal annual training is provided at the clinic on reviewing protocols and reporting laws. A guest

Table 4.1 Summary of Region I Clinic	
Evaluation Indicators	**Results**
	speaker from *A Safe Place* also gives a presentation about domestic violence at annual trainings. In addition, staff members receive updates on FIPV issues in the form of 'lunch and learn' meetings.
Eligibility for training	Everyone receives training, including front office staff.
Length of training	Incorporated into part of an all-day annual training. Updates last approximately one hour and are conducted four times per year.
Curriculum	Formal curriculum adopted from standard training material.
Frequency of updates	Updates provided quarterly through 'lunch-and-learn' meetings and newsletters.
Perceived usefulness by clinicians	Clinicians perceive training as useful and request worst-case scenario role plays at annual training.
Collaboration with Community Organizations	
Types of organizations	A shelter and the [state] Coalition Against Domestic and Sexual Violence
Length and type of collaboration	The safe house is located across the street. A representative from safe house meets with clients who express a desire for help. The coalition meets and discusses standards in health care and provides training on the issue of FIPV.
Involvement in protocol development and training	Staff from the safe house helped the clinic develop its FIPV screening protocol. Safe house also sends staff members to the clinic's annual training to provide training on FIPV. Social workers receive additional training from the coalition.
Frequency of communication	The safe house and the clinic communicate on a regular basis. The coalition meets formally every quarter; however, it is reported that e-mail communication occurs frequently.
Joint activities	

Region II: Community Health Center

Site description. The Region II clinic is a large community health center located in an urban setting. The three-story facility has a total of 10 exam rooms, an on-site laboratory, a dental office, and a teen drop-in center located in the basement. The clinic staff typically includes two full-time family practitioners as well as a full-time nurse practitioner. However, during the site visit, one of the family practitioners as well as the nurse practitioner were both out on maternity leave. In addition the clinic employs a dentist, a podiatrist, and an internist on a part-time basis. Services offered at the center include: family planning, pediatrics, dental care, podiatry, diabetes case management, asthma case management, HIV care, and teen services. On average the clinic provides care to approximately 200 patients per week, seeing more than 3,500 patients last year alone. The clinic director and two clinicians were interviewed during the site visit.

FIPV-related activities. FIPV has become embedded in the delivery of health care services at the clinic. Posters were seen on walls in the waiting area, exam rooms, and restrooms. Brochures were also present in all of these areas, with the exception of the ladies room. All new clients are privately screened at intake by a medical assistant or social worker with a written questionnaire, and the physician follows up with a verbal screening. Screening is performed at least once a year, and more frequently if the patient is either pregnant or a suspected case. Counseling and referrals are given to everyone reporting FIPV, and the social worker typically follows up with cases to make sure these clients are safe.

Part of developing an effective, comprehensive approach to dealing with FIPV has included employee education and staff development. Each year all employees are required to attend FIPV training. Training materials and curriculum were developed by the clinic, based on focus groups with patients and providers and a review of relevant research. The same local victim's assistance

agency to which the clinic refers FIPV cases participates in the clinic's staff training. Training has been effective, in the view of one physician, who reports that everyone, including the receptionists, have become better at recognizing FIPV before the patient even discloses such information. The director reports that the greatest barrier to training is neither resources nor employee attitudes, but finding the time to fit yet another activity into busy employee schedules.

One way the community health center has been able to maximize its FIPV capabilities has been through collaborations with other organizations and through taking advantage of local resources. As mentioned earlier, the health center has strong ties with a local shelter/victim's assistance agency. Similarly, the clinic takes part in community coalitions that serve as a means of networking with other agencies in the area. The director also noted that the city in which the health center is located has more resources than most, making it easier to both identify financial support and collaborate with other groups to accomplish a given task.

Table 4.2 Summary of Region II Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	The agency has extensive policies regarding FIPV screening. The protocols include both written and verbal screening of each patient. However, clinicians do not report following a universal "one size fits all" screening process for all patients and instead are allowed the flexibility to adjust the screening process as needed for each individual.
Usability	Both the director and the clinicians report that FIPV screening has been fully integrated into the system without overburdening caregivers and patients. By not establishing a rigid protocol that clinicians must follow during verbal screening, clinicians are empowered to use their best judgment in the approach they take to screening.
Perceived usefulness	All staff interviewed perceived FIPV screening as essential and useful in detecting cases.
Source and date of inception	Senior team management developed policy and protocols based upon focus group feedback and other research.
Changes in protocol	No changes noted
Barriers to implementing	No barriers noted
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	FIPV screening is mandatory for all initial patient visits and all initial prenatal visits. Policy also requires all patients to be screened at least once a year.
Criteria for screening	Screening is performed with all patients as part of their initial clinic visit and annually thereafter. In addition all initial prenatal visits include screening regardless of whether the patient has been screened within the past year.
Description	All new clients are privately screened at intake by a medical assistant or social worker with a written questionnaire, and the physician follows up with a verbal screening.
Perceived ease/discomfort of implementing	Neither the director nor the clinicians mentioned any difficulties in implementing FIPV screening. Incorporation of screening occurred smoothly for this clinic.
Methods to ensure confidentiality	Exam and screening are done with the patient alone in a private area. Provide hotline information via discreet business cards instead of bulky brochures.
Procedures following reported FIPV	Refer client to social worker who assesses whether or not the client is willing to accept help and counsels client on various options. If client does not want help at the time, the social worker informs her she can always come to the clinic for assistance in the future and provides her with information in case she changes her mind. If the client is willing to seek help, a referral to a partner organization is made. One clinician sometimes follows ups herself in cases where she is concerned.
Health Care Provider and Staff Training Programs	
Training provided	Training is provided to all clinic employees (receptionists, lab technicians, nurses, social workers, doctors, etc.).
Eligibility for training	All employees are required to participate in annual training.

Table 4.2 Summary of Region II Clinic	
Evaluation Indicators	**Results**
Length of training	Training takes approximately 45 minutes.
Curriculum	Annual in-service training is not based on a formal curriculum. Material presented focuses primarily on signs and symptoms.
Frequency of updates	Annually for all staff members with the exception of social workers who receive updates bi-annually.
Perceived usefulness by clinicians	Well received by clinicians.
Collaboration with Community Organizations	
Types of organizations	Community organizations representing a variety of causes including safe houses.
Length and type of collaboration	Long term, ongoing collaborations. Clinic participates in an anti-violence coalition.
Involvement in protocol development and training	Victim assistance agency assists the clinic with its annual training program as well as with patient referrals.
Frequency of communication	Communication between the clinic and community organizations occurs on a regular basis.
Joint activities	Neighborhood meetings and coalitions, employee training programs, and patient education in that the victim's assistance agency provides clinic with posters and brochures regarding FIPV and helpline telephone numbers.

Region III: Public Health Department

Site description. The clinic in Region III is a public health department located in a small town serving a rural population. The facility has three exam rooms, an on-site laboratory, a counseling room, and an activity room. In terms of general public health activities, the clinic is involved with multiple health education projects, hosts an annual health fair, facilitates provider education, and conducts community assessments. Clinical health care services offered include: immunizations, cancer screening, and family planning services. The clinic is the only full-time health care agency in the county. The family planning clinic typically schedules patient visits only 2 to 3 days per month, and on these days the clinic will usually see about 20 to 25 patients. However, walk-ins are accepted when a scheduled appointment is not an option or an urgent medical need arises. The clinic director and one clinician were interviewed during the site visit.

FIPV-related activities. The clinic has not established any formal policies or protocols with regard to FIPV prevention. Patients are asked one question about violence as part of the patient health history form. Patients are verbally screened if they indicate FIPV on the written form or if a member of the health care staff suspects FIPV. There are no specific guidelines the clinicians follow with regard to this verbal screening. The clinic does not provide staff with any FIPV training. In terms of handling identified cases, the clinic does provide materials and a hotline number to any client reporting FIPV.

The clinic makes an effort to display and provide materials on as many health topics as possible, including those related to domestic violence. The clinic had posters with a hotline number for FIPV in the waiting area and in the exam rooms. Brochures were available for patients to pick up, but the large number of brochures on a variety of topics makes finding FIPV material somewhat challenging.

The small-town setting of this clinic creates a situation where patients lack anonymity. The staff at the clinic reported that they personally knew most of the people who sought services there. An example of this lack of privacy is the case where a patient requested the staff to bring her in a

side entrance, so that someone working down the hall from the clinic's entrance would not see her. Staff also reported they did not perceive FIPV to be a problem in the community.

Table 4.3 Summary of Region III Clinic	
Evaluation Indicators	**Results**
Clinic Policies and Protocols	
Comprehensiveness	No formal policies or procedures in place.
Usability	Not applicable
Perceived usefulness	Not applicable
Source and date of inception	Not applicable
Changes in protocol	Not applicable
Barriers to implementing	Not applicable
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	Written screening at intake. Verbal screening during the exam if the patient indicates a violent situation or if abuse is suspected by the nurse or physician.
Criteria for screening	All patients are asked an FIPV question on the intake form. Verbal screening performed by the physician or nurse if they suspect abuse based on symptoms (bruising) or if a patient indicates abuse on the written form.
Description	One question on written screening form that patients complete. No formal verbal screening, although public health nurse screens and physician asks questions if patient seems at risk.
Perceived ease/discomfort of implementing	Clinic has had several incidents where a partner insisted upon accompanying patient into exam room; some escalated to the point where guns were aimed at staff. In order to avoid such dangerous situations, sometimes a patient may not be examined alone, and thus may not be verbally screened for FIPV.
Methods to ensure confidentiality	If the patient is accompanied by a partner, the clinician attempts to persuade him to wait in another room; the patient is then taken to an exam room where she can talk to the provider in private. The waiting room immediately outside the exam rooms has music playing, which prevents anyone from overhearing the patient and the clinician. Informal, non-specific notes are written in patients' charts in order to keep the information confidential. Sometimes patients choose to receive care in a nearby town where they are less likely to see someone they know.
Procedures following reported FIPV	Patient is given both oral and written information. A hotline number is offered for counseling and information. Counseling is offered at another center. At the follow-up visit the clinician attempts to discern if the abuse is continuing by talking to and observing the patient.
Health Care Provider and Staff Training Programs	
Training provided	None
Eligibility for training	Not applicable
Length of training	Not applicable
Curriculum	Not applicable
Frequency of updates	Not applicable
Perceived usefulness by clinicians	Not applicable
Collaboration with Community Organizations	
Types of organizations	Collaborates with one FIPV organization (HOPE Inc), local police, fire department, the local college, and businesses to stage events and talks. Uses these connections to enhance limited resources. Clinic director/nurse has given talks at a local college.
Length and type of collaboration	Long-term collaboration with a variety of organizations
Involvement in protocol development and training	Not applicable
Frequency of communication	Not applicable
Joint activities	Clinic Director worked with college to deliver an FIPV talk.

Region IV: Public Health Department

Site description. The Region IV clinic is a public health department located outside a major city, serving a mixed suburban and rural population. The facility houses many programs and offers a variety of services to the county. A wide range of patients are brought into the clinic by way of these other programs (e.g., tobacco, Safe Kids). The family planning division of the health department has three exam rooms and an on-site laboratory. This division of the clinic employs three full-time Nurse Practitioners (one of which serves as the Director of Nurse Practitioner Operations and does not work in a clinical setting full time) who focus primarily on family planning, sexually transmitted diseases, and general gynecological services. A physician, a pediatrician, and a breast test program specialist each visit the clinic on a weekly basis. The clinic does not currently employ anyone with direct education or experience in dealing with FIPV. On average the clinic provides care to approximately 60 patients per week. The clinic director and two clinicians were interviewed during the site visit.

FIPV-related activities. Health care practices at this particular clinic incorporate a minimal amount of FIPV screening and referral processes. The clinic does not have any established policies and protocols regarding FIPV screening. There was a poster – stating "Domestic violence is everyone's problem" and including a hotline number – on a wall in the waiting area as well as each of the exam rooms. There were no FIPV handouts or brochures available for patients. All patients complete a health history form at intake that includes a question about experiencing family violence. If a patient reports FIPV or if a clinician suspects FIPV, the clinician further screens the patient verbally. If FIPV is identified, the patient is referred to either a shelter or to the mental health division of the public health department. There is no written referral protocol in place.

The local shelter is within walking distance from the public health department. The employees of the health department know the shelter exists but do not know its exact location. They have a telephone number to pass on to patients if needed, and this is how they refer patients rather than working directly with the shelter. Employees at this clinic do not receive any formal training related to violence, and the staff does not include anyone with expertise in the area of FIPV. Staff members have attended conferences offering sessions on FIPV, but they expressed doubt about the utility of such brief sessions (30 minutes) and overall did not perceive these sessions as valuable. Although the health department has been able to collaborate with various local organizations, it does not have any collaborative relationships with groups concerned with FIPV.

Table 4.4 Summary of Region IV Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	Facility has no formal policies or procedures related to FIPV. They do report in the event the victim is a minor.
Usability	Not applicable
Perceived usefulness	Not applicable
Source and date of inception	Not applicable
Changes in protocol	Not applicable
Barriers to implementing	State and county have not made FIPV a priority in terms of legislation or resources. Clinic receives no materials or education with regard to FIPV from state or county.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	All clients fill out a health history form at intake that includes a question related to

Table 4.4 Summary of Region IV Clinic	
Evaluation Indicators	**Results**
	domestic violence. If the person answers yes to this question or if the health care provider suspects FIPV, the client is verbally screened during the exam.
Criteria for screening	Nurses verbally screen clients who indicate domestic violence on the intake form or those clients they suspect are victims of FIPV.
Description	No formal screening protocol exists. If nurse suspects or patient admits to being in an abusive situation, the nurse may ask some questions and provide the client with some basic materials.
Perceived ease/discomfort of implementing	Clinicians reported feeling frustrated when a patient shows obvious signs of FIPV but will not admit it. One clinician wondered to what extent patients in this situation should be encouraged to disclose the FIPV.
Methods to ensure confidentiality	Only ask patients questions about FIPV when they are alone. The facility makes a point to screen patients when alone.
Procedures following reported FIPV	Health care provider either provides the patient with the name and number of a local shelter or refers the client to the County's Mental Health Division.
Health Care Provider and Staff Training Programs	
Training provided	No training is provided to staff. Some of the staff have been to conferences and attended sessions on the issue.
Eligibility for training	No training provided.
Length of training	No training provided.
Curriculum	No training provided.
Frequency of updates	No training provided.
Perceived usefulness by clinicians	No training provided. It was expressed that conference sessions attended covered little material and were not very helpful.
Collaboration with Community Organizations	
Types of organizations	Clinic has no collaborative efforts with regard to FIPV prevention and assistance. Hospital system and sheriff's department in a neighboring county are resources. Also the public health department works with organizations whose interests are prenatal and pediatric care.
Length and type of collaboration	Ongoing collaborations, but not FIPV related.
Involvement in protocol development and training	Not applicable
Frequency of communication	Not discussed
Joint activities	Hospital system and public health department will refer clients to one another. The sheriff's department assists with displaced children and often attends local health fairs.

Region V: Family Planning/Reproductive Health Clinic

Site description. The clinic in Region V is a Planned Parenthood clinic located in an urban setting. The facility focuses on providing reproductive health care to low-income males and females. Services offered include STD testing and treatment, HIV testing, pregnancy testing, Pap exams, and birth control options. The clinic has six exam rooms, an on-site laboratory, and an education room. The clinic employs a Spanish-speaking clinician for translation purposes and multiple Sexual Assault Nurse Examiners. A volunteer for the YWCA Crisis Center also works at the center and is often the 'go between' if a patient is in crisis. Midwives from a local hospital visit the clinic once a week to examine pregnant clients. No licensed social workers/counselors are available to clients, but the Social Services Coordinator will speak with clients and refer them to social workers/counselors when requested. On average the clinic provides care to approximately 200 patients per week. The clinic director, two clinicians, and a health educator were interviewed during the site visit.

FIPV-related activities. All types of violence are taken seriously at the clinic, which sees more cases of sexual assault than domestic violence. As part of the patient history intake form, all patients are asked a question about domestic violence. When the patient is seen by the clinician, relationship issues are discussed in an informal manner, and if clinicians feels a patient is at high risk or shows signs (bruising) of FIPV, they verbally screen the patient. The clinician may refer the patient to the clinic's health educator or the Social Services Coordinator for further screening or assistance if they feel there is a need. If FIPV is identified, the health educator or the Social Services Coordinator speaks with the client. Police escorts and Child Protective Services are called if needed. Clinic staff try to find shelter for a client in crisis, if possible. At the very least, telephone numbers and a referral list are given to the client. On occasion, women have been taken out the back door of the clinic and walked to the crisis center by clinic staff. There were no posters related to FIPV on the walls of the clinic. The waiting room and the educational room each had one brochure on FIPV available for patients, and there were no FIPV-related materials observed in the exam rooms.

The clinic has collaborated with various local organizations, including some that deal with FIPV and sexual assault. The facility is within walking distance of a hospital and a YWCA Rape Crisis Center. The clinic refers patients to this organization if FIPV is suspected, as the center offers a safe haven for women experience domestic violence. The clinic hires the YWCA to provide in-depth employee education. The clinic has also identified other local service providers to whom they refer patients in need of services not offered at the clinic itself; similarly, these agencies refer patients to clinic for certain services. For example, if patients needs substance abuse counseling, the clinic refers them to a local organization that can provide the service, whereas the substance use treatment center refers to the clinic patients who need reproductive health or family planning services.

Table 4.5 Summary of Region V Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	The clinic is required to follow Planned Parenthood's policies at a minimum and has opted to exceed those requirements with a more comprehensive FIPV screening program.
Usability	All clinicians reported being comfortable with the current FIPV screening policies and procedures. No complaints were made about the process itself.
Perceived usefulness	Staff expressed concern about FIPV and sexual assault and felt the policies and protocols in place were essential and in the best interest of the patient. At the same time, clinicians noted that many FIPV cases do not answer truthfully to screening questions and, even when they do, are sometimes not open to seeking help.
Source and date of inception	Not discussed
Changes in protocol	Not discussed
Barriers to implementing	None mentioned
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	Screening occurs at intake as part of health history forms and social history forms. Clinicians do not screen unless they feel someone is at high risk, shows signs of FIPV (bruising), or has indicated FIPV on the intake form.
Criteria for screening	Screening performed on all patients as part of their initial visit and annually thereafter.
Description	Written screening as part of intake and an informal discussion about relationships with nurse practitioner. Further verbal questioning may occur if the patient presents with signs or symptoms of FIPV.
Perceived ease/discomfort of implementing	No difficulties reported

Table 4.5 Summary of Region V Clinic	
Evaluation Indicators	Results
Methods to ensure confidentiality	Only patients are allowed in exam rooms with the exception of obstetrician visits.
Procedures following reported FIPV	The Social Services Coordinator speaks with the client. Police escorts and Child Protective Services are called if needed. Shelter is found for the client if possible. At the very least, telephone numbers and a referral list are given to the client. The Social Services Coordinator completes a referral form.
Health Care Provider and Staff Training Programs	
Training provided	Clinic provides all staff with educational opportunities to attend conferences and lectures on topics related to FIPV. Clinicians can attend both state-sponsored and local training. Some nurses also reported having attended a conference hosted by DHHS on the topic of domestic violence.
Eligibility for training	All staff members are invited to attend sessions.
Length of training	Training provided by the YWCA was reported to take approximately 50 to 60 hours.
Curriculum	YWCA curriculum includes on-site training, role playing, general education, and lectures by guest speakers.
Frequency of updates	No regular updates are provided.
Perceived usefulness by clinicians	Staff spoke positively about the training received, but did express a desire for more continuing education opportunities.
Collaboration with Community Organizations	
Types of organizations	The YWCA, a local association outreach program, a substance abuse center, a behavioral health clinic, and a rape crisis center are all collaborators.
Length and type of collaboration	The clinic is within walking distance of a local YWCA that offers a wide range of services to assist victims of FIPV and sexual assault. The YWCA houses both a rape crisis center and a shelter, provides counseling, assists people in locating shelters and halfway houses, and helps people with children apply for Medicaid. Not only does the clinic refer patients to this agency, it also contracts with the YWCA to provide employee FIPV training. The clinic works with the local association on cases where they detect problems in the home. The association sends a social worker to the home to check up on the patient and provide resources to the person/family. Referral is made without patient consent. The substance abuse center, behavioral health clinic, and rape crisis center are all places to which a clinician may refer a patient to receive services not provided by the clinic.
Involvement in protocol development and training	YWCA provides educational lectures to the staff on domestic violence.
Frequency of communication	Communication occurs on a regular basis.
Joint activities	

Region VI: Public Health Department

Site description. The clinic in Region VI is a public health department located in a small city, serving a rural population. The facility focuses on providing family planning services, but other services offered include: STD screening and treatment, HIV testing, TB testing and treatment, and flu immunizations. This county health department has three large exam rooms and five private clinician offices. The clinic currently has nine staff members who work on-site, five of whom are nurses. Two additional nurses are part of off-site services to at-risk families. The clinic director and three clinicians were interviewed during the site visit. Drug abuse is high within the county (and the state) and this, combined with the isolation experienced by many of the citizens, seems to promote instances of FIPV. As a result, the state and the county have committed resources to FIPV prevention.

FIPV-related activities. The clinic follows the state's established policies and protocols regarding FIPV screening. It also uses the state's health history intake form, which includes

questions about FIPV. The clinic has many take-away materials available for patients specific to FIPV, although the topic is sometimes integrated into other types of materials for parents, young people and at-risk families. No posters related to FIPV were on the walls in the clinic but a poster with a toll-free number for FIPV assistance was located in the ladies' restroom.

Written screening for FIPV is included in a questionnaire that patients complete at intake. Screening questions are integrated into the subjective objective assessment planning (SOAP) general medical screening guidelines. When a patient meets with the nurse practitioner in the clinician's office, she/he is encouraged to talk about any problems she/he may be experiencing. Concurrently, the nurse practitioner notes any signs of physical violence the patient may show. If the patient is reluctant to reveal any information, the nurse practitioner asks questions specifically related to violence. If a patient is identified as experiencing FIPV, the nurse manager meets with the patient in private and offers counseling and referral information. Usually the patient is presented with options about what to do and where to go if she/he is experiencing FIPV. Follow-up occurs in cases where the patient's situation is deemed very serious and the nurse is concerned about her/his well-being.

The remote location of this clinic has presented several challenges with regard to both employee education and patient referrals. For example, FIPV training is not available locally, and staff must drive about four hours one-way to attend training. Ultimately, this requires staff to stay out of town overnight. Overnight expenses are costly, but overnight stays also mean that clinicians are not available to see patients for a greater-than-usual time period. Likewise, the clinic has been limited in its capacity to form collaborative relationships with local organizations because there are simply not many local resources available. The community has a safe house to which the clinic can refer patients; however, during interviews several clinicians and the Clinic Director noted that most community members are aware of its location, which compromises its effectiveness as a sanctuary. One interviewee suggested the system be changed so that victims are transported to safe houses in other communities to help ensure a more confidential and safe location.

Table 4.6 Summary of Region VI Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	Clinic follows guidelines established by state, but has no site-specific policies or protocols.
Usability	Staff reports the protocol is user-friendly. A new form currently being piloted is more in-depth and easier for the patient to understand.
Perceived usefulness	Perceived as useful by staff and clients.
Source and date of inception	The protocol follows the state's Title X policies and protocols. Date of inception was not known.
Changes in protocol	Have always followed state's protocol/requirements.
Barriers to implementing	A large, sparsely populated geographic area is served by the clinic, making it difficult for victims of FIPV to return to the clinic for further assistance. Rooms are not sound-proof making it difficult to ensure patient privacy when disclosing such issues. There is only one safe house in the community, and most people know where it is located.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	Written screening takes place at intake as part of the state health history form. A nurse reviews the form with the patient in the exam room. Patients complete this form annually. Also all prenatal and postpartum visits include verbal screening during each visit. In-home visits to at-risk families are used as an opportunity to identify FIPV.

Table 4.6 Summary of Region VI Clinic	
Evaluation Indicators	Results
Criteria for screening	All patients are screened with the exception of young children coming in for immunizations.
Description	Screening for FIPV begins by filling out a questionnaire that contains questions related to domestic violence. These questions are integrated in the subjective objective assessment planning (SOAP) general medical screening guidelines. The patient then meets with the nurse practitioner in the clinician's office and she/he is asked about any problems she/he may have. Concurrently, the nurse practitioner pays attention to any signs of physical violence the patient may show. If the patient is reluctant to provide any information, the nurse practitioner asks questions specifically related to violence.
Perceived ease/discomfort of implementing	Staff is comfortable with the screening method.
Methods to ensure confidentiality	Clinic typically tries to keep partners and parents in the waiting area. In cases where a partner/parent is present in the exam room and FIPV is suspected, the nurse either transfers the patient to another private exam area or asks the partner/parent to step outside the room.
Procedures following reported FIPV	Once a patient is identified as experiencing FIPV, the nurse manager meets with the patient in a private office and offers counseling and referral information. Usually the patient is presented with options on what to do and where to go to in the event of FIPV. Follow-up occurs in cases where the patient's situation is deemed very serious and the nurse is concerned about the patient's well being.
Health Care Provider and Clinic Training Programs	
Training provided	Training is provided by the state annually. In addition, the clinic provides updates as part of staff meetings.
Eligibility for training	All clinicians are trained.
Length of training	Annual training typically lasts 1 to 2 days.
Curriculum	Curriculum is developed by the state and in accordance with federal guidelines.
Frequency of updates	Updates were reported to be provided once a month at staff meetings.
Perceived usefulness by clinicians	Staff were positive about the material covered during training but frustrated by the distance they were required to travel in order to attend. The expense and time demand associated with traveling to the training was viewed as limiting staff training opportunities.
Collaboration with Community Organizations	
Types of organizations	A local hospital, the local schools, a nearby safe house, and the local churches.
Length and type of collaboration	Some patients are referred to the local hospital for exams and treatment not offered at the clinic. Clinic staff visit several local schools and provide in-service education on sexual assault. Brochures are provided to the students on the topics covered. The clinic and the safe house refer clients to each other for services. It was also mentioned that many of the local churches provide food and other essentials to women who are trying to escape FIPV.
Involvement in protocol development and training	Not applicable. Protocol and training come from the state.
Frequency of communication	Not discussed
Joint activities	Not discussed

Region VII: Family Planning/Reproductive Health Clinic

Site description. The clinic in Region VII is a Planned Parenthood clinic located in a medium-sized city, serving primarily urban clients but also seeing some rural clients. The primary focus of the clinic is family planning, but other services offered include: STD testing, pregnancy testing, Pap exams, and birth control. The clinic has five exam rooms, two on-site laboratories, and a conference room that is in the process of being converted to a library. The clinic employs

two nurse practitioners, a health educator, a medical assistant, a full-time RN, and two part-time RNs. On average the clinic provides care to approximately 400 to 500 patients per month. The clinic director, two clinicians, and a health educator were interviewed during the site visit.

FIPV-Related Activities. The clinic follows the FIPV screening guidelines established by the PPFA. The clinic conducts FIPV screening at intake as part of each patient's health history form. The Clinic Director has developed and included multiple questions on this form to help identify FIPV. This form is reviewed by the nurse or nurse practitioner prior to and during the patient's visit. If domestic violence is noted on this form, the nurse or nurse practitioner asks further about it and provides support at the patient's request. If domestic violence is not noted on this form, yet the nurse practitioner feels that it is likely (due to nonverbal cues such as 'the shakes'), the nurse practitioner probes for information. No formal referral system is in place. Patients are given information and, if the patient is a minor, the Child Protective Services are called.

Not all of the waiting or intake rooms offered privacy, and the clinic did not have many visible materials related to FIPV. No posters were observed in the clinic during the site visit, and the brochures in the waiting area were placed in the corner somewhat out of sight. The clinic had brochures and materials related to FIPV that they would distribute to patients as the need was identified. Exam rooms were private, and the clinic has a strict policy about seeing the patient alone in the exam room. In addition, the clinic reserves one of its exam rooms for cases requiring extreme privacy, such as FIPV cases.

Not all clinicians receive training related to FIPV. The clinic has developed a comprehensive training program, but the training is not mandatory and has not been widely requested. The Sexual Assault Nurse Examiner is the only one required to have such training on a regular basis. A nurse uncomfortable with handling FIPV cases stated that more training would be helpful, in that clinicians would feel more confident in their approach.

This clinic has been well-received in the community and, as a result, has been able to become involved in the community and with other local organizations. The health educator has been able to do presentations in schools about FIPV. This clinic has been asked to give presentations at local PTA meetings. The health educator has been able to build relationships with many groups, and in the future hopes to be able to do more presentations on FIPV. The clinic also works closely with two local crisis centers to which it makes referrals in cases of FIPV.

Table 4.7 Summary of Region VII Clinic

Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	All patients are screened at intake with a health history form that has several questions regarding FIPV. Verbal screening is done only with patients reporting violence on the intake form or if the nurse suspects violence based on nonverbal cues (bruising, shaking, etc.).
Usability	Written tool was described as an easy way to gain background information about a patient. Clinician did mention feeling uncomfortable about bringing up the topic with patients.
Perceived usefulness	Staff noted that the majority of FIPV cases do not indicate violence on the written form, and those that do are indicating past abuse. Verbal screening was seen as being more useful. Building rapport with the patient as well as repetition were both mentioned as key elements of verbal screening.

Table 4.7 Summary of Region VII Clinic	
Evaluation Indicators	**Results**
Source and date of inception	Follow PPFA policies and protocols.
Changes in protocol	Not discussed
Barriers to implementing	In the past, language barriers have been an issue, but recently the clinic has been able to add some Spanish-speaking members to the staff to address this problem. Not all staff have received formal training on FIPV.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	All patients are screened at intake with a patient history form that includes several questions related to FIPV. If the patient indicates domestic violence on the form the nurse practitioner probes verbally before the exam. Similarly, if the nurse practitioner suspects FIPV, the patient is verbally screened.
Criteria for screening	All new patients are screened when they fill out initial paperwork. Also all suspect cases are screened by the nurse practitioner.
Description	Written screening at intake administered to all patients and verbal screening of patients that either have indicated FIPV or are suspected cases.
Perceived ease/discomfort of implementing	It was reported that the Sexual Assault Nurse Examiner and Spanish-speaking nurse practitioner have both made screening easier. One clinician expressed apprehension about approaching the subject with patients.
Methods to ensure confidentiality	Patient is seen alone. Parents/partners are not allowed in the exam room unless the patient requests it, and only after the nurse practitioner has had the chance to talk with the patient alone.
Procedures following reported FIPV	No formal referral process is currently in place. If a minor is experiencing domestic violence then the authorities are notified. Clinic workers provide all other FIPV cases with materials and brochures developed specifically for these instances.
Health Care Provider and Staff Training Programs	
Training provided	No training related to FIPV is provided to staff with the exception of the Sexual Assault Nurse Examiner.
Eligibility for training	Only the Sexual Assault Nurse Examiner receives formal training.
Length of training	Not discussed
Curriculum	Not discussed
Frequency of updates	The Sexual Assault Nurse Examiner receives training updates at least once per year.
Perceived usefulness by clinicians	Clinicians reported a desire to have FIPV training and felt it would help them perform their duties more effectively.
Collaboration with Community Organizations	
Types of organizations	Two local crisis centers, local schools, some local PTAs, National Organization for Women, and the state chapter of the Religious Leaders for Reproductive Choice are collaborators.
Length and type of collaboration	Clinic refers FIPV cases to two different local crisis centers with which the clinic educator communicates on a regular basis. Also the clinic's educator has done educational presentations for some of the local schools as well as some PTA chapters on various topics, including FIPV. Brochures are mailed to schools advertising various educational programs offered by the clinic. Schools/educators can then choose which programs, if any, they would like to have presented to their students. The clinic also works with other organizations to increase community awareness of FIPV.
Involvement in protocol development and training	The clinic offers training to their collaborating organizations related to FIPV.
Frequency of communication	Communication is regular and ongoing.
Joint activities	Clinic worked together with schools to give talks about FIPV and participates in a number of activities to raise awareness about FIPV, particularly sexual assault.

Region IX: Family Planning/Reproductive Health Clinic

Site description. The clinic in Region IX is a Planned Parenthood clinic located in an urban setting. The facility offers comprehensive services including reproductive services to males and females, primary care, pediatrics, and sterilization services. The clinic has 8 to 9 exam rooms. Normally the clinic operates with a staff of 35 employees. However, at the time of the site visit only 24 employees were working for the clinic. The clinic sees approximately 100 patients per week. The Clinic Director, who is also the lead FIPV trainer, and two clinicians were interviewed during the site visit. A telephone interview was also conducted with the staff person at the agency's headquarters who is responsible for training programs.

FIPV-related activities. The Clinic Director is also the affiliate-wide consultant for FIPV. The clinic takes FIPV seriously and stays current with the latest recommendations related to this topic.

This clinic has developed and institutionalized formal FIPV policies and protocols. The formal policies and protocols were developed primarily in response to the state's mandatory reporting laws and are updated regularly to ensure compliance with state laws and PPFA guidelines. All visits to the clinic begin with a general health history that includes FIPV screening questions. This health history is given to all patients at every visit. If a client answers affirmatively to any of the screening questions, a health services specialist follows up with a verbal screening and alerts the attending physician or nurse practitioner. During the exam, FIPV is then further discussed with the patient. The clinician also informs the client of the mandatory reporting obligations and their privacy rights. After the exam, the clinician follows up with the client to facilitate and inform her/him of options and provide referral and resource information. If the client indicates she/he would like assistance, the clinician refers them to Women Escaping A Violent Environment and provides resource information related to the organization. If the client would like to make an official report, the clinic coordinates among staff to arrange a time where the client will be safe and the reporting will be kept private.

The clinic ambience was also conducive to FIPV screening. The facility was clean, professionally run and looked like a state-of-the-art medical clinic or service provider. Exam rooms were large and private. There was a private room for patient intake screenings. Resource materials for a local organization the clinic collaborates with were displayed and available in all the exam rooms. FIPV materials were not clearly noticeable in the waiting area, although there was a flyer for WEAVE among the other materials. In addition, all of the restrooms had resource materials from WEAVE.

The clinic places a high value on training employees to effectively handle FIPV cases. Employees participate in an in-service training developed for use agency-wide. In the past, staff were also sent to educational programs offered by a local women's shelter. The training provided by the agency covers FIPV policies and protocols, in addition to information about the social aspects and psychological effects of abuse. Training materials were reported to create a strong emotional response in clinicians and, as a result, intense discussions tended to occur during training sessions. The training also included role plays to help clinicians feel more comfortable in dealing with FIPV.

Table 4.8 Summary of Region IX Clinic	
Evaluation Indicators	Results
Clinic Policies and Protocols	
Comprehensiveness	Have formal policies and procedures established. The policies and procedures are somewhat complicated due to the state's reporting requirements.
Usability	It was reported that policy and protocols are easy to follow, and when any issues come up they are quickly resolved.
Perceived usefulness	Viewed as essential in ensuring all clients are given an opportunity to seek help if they need it.
Source and date of inception	Director was unsure of the source and date of inception. Vice President of training reported that the protocol was developed in response to mandatory reporting laws.
Changes in protocol	Changes are made on an ongoing basis by both the Clinic Director (in his capacity as lead FIPV trainer) and PPFA, based on the latest research and at the request of staff.
Barriers to implementing	The Clinic Director reported that finding the time to train staff has been the greatest challenge to implementing FIPV policies and protocols. It was mentioned that the clinic must either close or run with a minimal staff during training.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	All patients are screened at intake as well as at every visit. If the client answers affirmatively to any of the screening questions, a health services specialist follows up with a verbal screening and alerts the attending physician or nurse practitioner. The patient is then asked about the FIPV during their exam.
Criteria for screening	All patients are screened with a written health history at all visits. Only patients who indicate abuse are verbally screened. Clinicians also screen patients they suspect of experiencing FIPV.
Description	Screening begins with the general health history form that includes questions related to FIPV. If the client answers affirmatively to any of the screening questions, a health services specialist follows up with a verbal screening and alerts the attending physician or nurse practitioner.
Perceived ease/discomfort of implementing	It was reported that some staff do not feel comfortable with FIPV cases and sometimes turn such cases over to someone more experienced. In addition the reporting requirements for this particular state are quite complicated, and some clinicians find them confusing. Training was reported to help boost staff member comfort level. In addition, clinicians with more experience in FIPV helped with cases when other staff were uncomfortable.
Methods to ensure confidentiality	No one can accompany a patient into an exam room until after the patient has been screened alone by the clinician. Also information regarding FIPV is recorded on a separate form that is not part of the chart. The information on this form is protected and is not copied.
Procedures following reported FIPV	The clinician informs the client of the obligation for mandatory reporting and their privacy rights. Later the clinician follows up with client to facilitate and inform the client of options and provide referral and resource information. If the client indicates she/he would like assistance, the clinician refers the client to WEAVE and provides resource information related to the organization. If the client wishes to make an official report, the clinic coordinates among staff to arrange a time when the client will be safe and the reporting will be kept private.
Health Care Provider and Staff Training Programs	
Training provided	Clinic tries to have all staff participate in the FIPV education program developed by the consortium. Training is sometimes quite emotional so several members of consortium staff attend.
Eligibility for training	All clinical and front-line staff receive training.
Length of training	There are two different curricula: a two-hour and a one-day format. The two-hour course is used as an update or when an ad hoc training is scheduled.
Curriculum	Includes training on medical aspects, policy aspects, and social aspects of FIPV. Addresses clinician concerns and role plays counseling experiences.

Table 4.8 Summary of Region IX Clinic	
Evaluation Indicators	**Results**
Frequency of updates	There is no set schedule for training updates. Typically updates are provided in October but may also be done at other times if a clinic is experiencing a high rate of FIPV or has a large number of new staff.
Perceived usefulness by clinicians	Clinicians reported that the training program relieved some anxiety, particularly with regard to state laws and referrals.
Collaboration with Community Organizations	
Types of organizations	WEAVE, teen program run through youth center, and organizations that deal with Hispanic and Asian populations.
Length and type of collaboration	Have worked closely with WEAVE for many years. WEAVE has served both as a resource for the clinic and as a referral agency.
Involvement in protocol development and training	WEAVE used to train staff at the clinic. However, after obtaining a grant, clinic staff went back and retrained WEAVE staff. Clinic staff have worked WEAVE's 24-hour hotline.
Frequency of communication	Clinic communicates with WEAVE on a regular basis, but less often with the other organizations.
Joint activities	

Region X: Public Health Department

Site description. The site visited in Region X is a county public health department located in a small town and serving a rural population. This clinic offers services to indigent and underserved populations. The health department houses a family planning clinic, provides immunizations, conducts activities to monitor and control the spread of infectious disease, provides WIC services, and has a bioterrorism preparedness program. Recently this health department has had to reduce its staff due to funding cuts, and currently the department is running understaffed. The clinic was large but it appeared that some of the building was empty and unused. The Clinic Director and two clinicians were interviewed during the site visit. One clinician who was a 'point person' for FIPV was away at a training during the visit and, therefore, could not be interviewed.

FIPV-related activities. Staff at the clinic recognize FIPV is a problem in the communities they serve and would like to be able to do more to address the problem. Lack of resources and local politics were both cited as reasons the clinic has not developed a comprehensive FIPV prevention program. The clinic already lacks necessary staff. It was reported that the subject of FIPV is also still taboo in the region. In addition, the population served is widely dispersed in a large, rural county, which makes providing service a challenge. To overcome this challenge, clinicians are assigned to state-funded in-home programs for families at risk. These individuals travel to homes and provide health education and medical services. These clinicians use the in-home visits as an opportunity to identify and prevent FIPV and have methods to get the victims alone, assess their safety, and provide referrals privately. Clinicians are assigned to particular families so they visit the same homes one or more times per month for more than a year, providing ample opportunity to build trust and create a rapport with someone experiencing FIPV.

Currently the clinic does not have any developed FIPV prevention program. Clients are screened informally for FIPV. All patients are asked two questions related to FIPV as part of the intake screener. If the client indicates abuse, or if a clinician suspects abuse, the clinician asks about FIPV. Referrals are typically made to the hospital's domestic violence unit or to one of the local

safe houses. The clinic has materials related to FIPV in exam rooms and in the hall area near the entrance. An FIPV training video is offered to all employees but is optional for some staff.

Table 4.9 Summary of Region X Clinic	
Evaluation Indicators	**Results**
Clinic Policies and Protocols	
Comprehensiveness	No formal policies or protocols in place.
Usability	Staff did not express a desire to have a more formalized program.
Perceived usefulness	Mixed feelings about the effectiveness of screening. One clinician reported that she had a way of getting clients to open up over time; other clinicians felt that most victims deny FIPV, making screening ineffective. In-home providers use the visits as opportunities to identify FIPV.
Source and date of inception	Not applicable
Changes in protocol	Not applicable
Barriers to implementing	Lack of resources was mentioned by some respondents as a barrier. It was also stated that the topic of FIPV is still taboo in the area.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing	Written screening is done at intake. Clinician verbally screens during exam if patient indicates abuse or if clinician suspects abuse.
Criteria for screening	Written screening FIPV questions posed to all patients. Use Maternal Case Management Assessment tool to identify suspected cases for follow-up with verbal screening.
Description	Two FIPV questions on the intake screener for the family planning clinic. The prenatal program's referral form also includes the referring agency's assessment of FIPV, and the program's in-home checklist has several sections to complete after the first in-home visit that are applicable to FIPV. Clinician talks to patients and is alert for signs of abuse.
Perceived ease/discomfort of implementing	No difficulties reported
Methods to ensure confidentiality	Clinicians try to see patients in private. In-home provider waits to get patient alone by asking for a glass of water or tea, then gives the person a small shoe card.
Procedures following reported FIPV	Referrals after family planning visit were not described. Not able to interview the clinician who was unexpectedly out of the office. For the in-home visits, if the situation is private, the nurse talks with the patient about safety plans and community resources if she is ready. If not, nurse plans more visits with the patient to monitor the situation.
Health Care Provider and Staff Training Programs	
Training provided	Receive training through a video.
Eligibility for training	All WIC counselors are required to watch the video; others may chose to view as well.
Length of training	The video is about a ½ hour long.
Curriculum	Not applicable
Frequency of updates	Updates were formerly annual, but have not been kept up.
Perceived usefulness by clinicians	Staff felt current training needed to be reviewed and revised. Reported a desire to have additional information and training on the topic of FIPV.
Collaboration with Community Organizations	
Types of organizations	The health clinic works with two local organizations. One deals primarily with empowering women to stand up for themselves, and the other is a family support group that helps with children as well. In addition, the clinic works with two different safe houses.
Length and type of collaboration	These are all organizations to which the clinic refers patients.
Involvement in protocol development and training	Not applicable
Frequency of communication	As needed
Joint activities	Not discussed

5.0 Summary and Conclusions

In this section, the characteristics of the sites visited and a summary of the findings from the sites are presented (5.1). Following the summary of finding from the sites, the primary objectives of the study are discussed in light of the findings (5.2).

5.1 Summary of Findings from the Site Visits

The clinics visited represented a mix of urban and rural clinics, and community health centers, county public health departments, and reproductive health clinics (Planned Parenthood clinics). One clinic was visited in each of 9 of the 10 DHHS regions. The clinics were chosen because they reported in an earlier study that they screened patients for FIPV. Sites visits were conducted from April through November 2004 and included key informant interviews, a site tour, and collection of materials and documents used by the clinic relating to FIPV.

During the site visits, 9 Clinic Directors, 17 clinicians, 2 health educators, and a Vice President in charge of training were interviewed. Interviews were unstructured and lasted from 20 minutes to two and one-half hours. Seven of the Clinic Directors were also part time clinicians. Clinicians were primarily nurse practitioners, but also included three physicians, as well as several registered nurses and social workers. Though unstructured, the interviews covered four primary areas of interest: clinic policies and protocols, routine screening procedures for FIPV, health care provider and staff training programs, and collaboration with community organizations.

The site visits also included observations of clinic facilities including the exam rooms, offices, waiting rooms and restrooms to look for the presence of FIPV materials as well as to note the location and privacy of the rooms. Results of the observations are incorporated into the site descriptions in Section 4.0. All of the clinics had multiple exam rooms, although at least three of them had rooms that were not sound-proof. In all cases, staff were aware of this and either moved patients who needed privacy or used music outside of the exam rooms to muffle the conversations

During the site visit, materials and other documentation about the FIPV prevention activities at the clinic were collected and later catalogued. Appendix E lists and describes the materials and documents. Names and other identifying information have been removed from the descriptions. Initially, the collection of materials and documents included well over 100 different pieces. Duplicates and items that were not strictly related to FIPV were eliminated but the resulting list still includes 90 items collected from the clinics. The types of items include brochures, clinician materials, handouts and postings, in both English and Spanish. Sources of these were from the state, county, or federal governments and from domestic violence organizations. A few were developed by the clinic or the clinic's managing agency.

Recognition of FIPV as a problem that the clinic should address varied among the clinics and was often tied to the states' or the communities' concerns about FIPV or the particular interest of one or more staff members. The state, either through active FIPV programs or legislation such as mandatory reporting of FIPV, was an important factor in the Region II, VI, VII, and IX clinics. Seven of the nine clinics also had one or more staff members who expressed interest in and dedication to FIPV prevention. These two factors together seemed to promote the most extensive

FIPV programs that were encountered. Three of the clinics' FIPV programs consisted only of written screening questions and a concerned clinician. Staff in these three clinics were concerned about FIPV but noted a lack of resources, their community's lack of concern about FIPV, or the stigma associated with FIPV as limiting factors.

As noted above, all of the clinics conduct written screening of all patients at intake and then at least annually after that. Verbal screening is done when the patient indicates FIPV on the written screener, when there is some evidence of abuse (e.g., bruises, cuts), or when the clinician suspects or intuits that FIPV may be a concern. Eight of the clinics displayed posters about FIPV or had brochures or information readily available for patients. These were sometimes in the waiting rooms but often in the exam rooms or ladies' restrooms. Training was important to the clinicians. Six of the clinics have formal training programs, although the methods and formats varied from ½-hour videos to two-day trainings in FIPV. Several sites conducted updates about FIPV during regular meetings or in-services. Several clinicians and Clinic Directors expressed the desire for additional training in FIPV. Finally, all of the sites collaborated with community agencies to some extent. Region III had a unique approach, working with schools, unions, and local businesses to raise awareness about FIPV.

5.2 Study Objectives

As noted in Section 1.0, there were three overarching objectives for conducting the site visits to the Title X-supported clinics. Below each objective is discussed in light of the study findings.

Assess the extent to which strategies used to implement FIPV integration have been acceptable to program providers, and whether program staff perceive them to be effective and sustainable. All of the Clinic Directors and clinicians appreciated the importance of the FIPV prevention activities and viewed them as an integral part of the clinic's activities. Clinicians consistently followed up when FIPV was noted in the written screenings. In addition, clinicians verbally screened for FIPV if they found evidence of injuries or bruising or if they suspected FIPV was a concern. Most of the clinicians talked about using their experience or intuition to identify patients who should be verbally screened for FIPV, even if they did not show physical evidence of injury or trauma. None of the clinic staff interviewed saw the FIPV prevention activities as being particularly burdensome, although a few noted that their time was limited and that addressing FIPV with patients was time-consuming. In some communities, more pressing concerns often limited clinicians' time for FIPV. Some of the clinicians felt it was difficult to persuade patients to admit FIPV, even if they were asked directly and privately. In these cases, clinicians offered the client information about resources and usually made an ambiguous chart note that would indicate follow-up at the next visit.

Identify the impact of FIPV prevention activities on the implementing organizations and arrive at implications for the program on wider integration of FIPV activities in Title X clinics, including some measures of cost of program to the clinic. The comprehensiveness of the FIPV prevention activities varied widely, depending on the size and location of the clinic as well as the services offered. Generally, the FIPV prevention programs were 'in keeping' with the size of the clinic, its location, and the services offered, thus impact did not vary greatly across the clinics. Smaller clinics, rural clinics, and those offering more limited family planning services had correspondingly smaller FIPV prevention programs. For example, the clinics in Regions III, IV,

and X were relatively small, public health department clinics where family planning was only one of many services offered, so their FIPV prevention activities were correspondingly simple, although not necessarily less effective. Conversely, Regions I, II, V, and IX had the most comprehensive programs in terms of staff training, referrals, and community collaborations. All of these clinics are large and offer comprehensive services. Two are located in large cities and one in a medium-sized city where many opportunities for referrals and collaborations exist.

Costs of the FIPV programs were mostly costs related to staff time for training, if applicable. Even the clinics that conducted the most comprehensive staff training did not track the costs specifically related to the FIPV training. There was either an overall training budget, or the FIPV training was incorporated into regular staff time. The protocols and policies for all but two of the clinics were adapted from state, regulatory or parent organizations or agencies. Materials were also obtained at minimal or no cost from government agencies or FIPV-related foundations and community-based organizations. None of the clinics had a staff person dedicated to FIPV prevention – all were clinicians, social workers, or health educators who responded to a variety of patient needs. For all the clinics, FIPV prevention was imbedded within the provision of care.

Identify specific strategies that the Office of Population Affairs (OPA) and collaborating agencies can utilize to raise awareness about FIPV and to achieve better integration of FIPV prevention activities into public family planning services. This objective will be further addressed in the forthcoming promising practices report. The findings from the site visits suggest several useful strategies:

- Clinicians are a key factor in screening for and identifying FIPV. Clinicians working at clinics with basic FIPV programs still made a significant contribution to FIPV prevention as caring and interested health care providers. Most were open to additional training in FIPV, and clinicians in rural areas were particularly interested in ways to obtain professional training in FIPV prevention.
- Organized training programs can be brief, such as a one- or two-hour in-service. Clinicians appreciated training that helped them to overcome anxiety about talking to a patient about FIPV. Training programs also stressed that helping someone experiencing FIPV sometimes took longer to get results than other concerns and that sometimes resolution never occurred.
- Community collaborations were important to many of the clinics' FIPV prevention programs. Collaborators provided materials to display and distribute to patients, and also provided training to the clinic staff. They further helped the clinic respond to patients in crisis, sometimes immediately. Even if the community collaborators were not called by clinicians to help with a particular patient, they were important places of patient referral.
- The site selection criteria for this study meant that only clinics with some interest in FIPV prevention would be taking part in it. However, in every clinic visited, there seemed to be one or two people who were the most committed to FIPV prevention, serving as a 'point person' and furthering the FIPV prevention activities.

A. Invitation Letter to Clinics

Dear [NAME]:

Battelle Centers for Public Health Research and Evaluation has been asked by the Office of Population Affairs (OPA) to conduct an in-depth study of family and intimate partner violence (FIPV) prevention activities in nine clinics that provide family planning services. We are writing to request [CLINIC NAME'S] participation in this study. An introductory letter from OPA is attached that describes the background and objectives of the study. Please note that the enclosed letter from OPA is not addressed to you or your clinic as we have kept OPA blind to your clinic's name and address until you agree to participate.

As you may remember, your clinic participated in a survey conducted by Battelle for the Centers for Disease Control and Prevention (CDC) in 2001 about FIPV prevention. The present study is a follow-up to that survey. CDC and OPA were excited and pleased about the results of the survey and were impressed with the level of FIPV prevention activities that clinics were conducting. CDC's Division of Reproductive Health is now developing a newsletter reporting the results of the study that should be available shortly. Based on the results of the study, OPA decided to fund this study to take a more comprehensive look at FIPV prevention in a small number of clinics with the goal of developing promising practices guidelines that will be useful for all clinics providing family planning services.

The final group of nine clinics included in the study will reflect a balance of clinic type, size, location, population served and previous FIPV prevention activities. [CLINIC NAME] was selected based on these criteria.

Involvement in the study requires your willingness to participate in two activities.

- Two staff members from Battelle will conduct a visit to your clinic sometime this summer. The visit will take a few hours and we will schedule it at your convenience. During the visit, we would like to interview 2-3 members of your staff about their responsibilities and activities regarding FIPV prevention. In particular, the discussions will cover the services they provide, the training they have received, the infrastructure and resources they have available, and the successes and challenges they have experienced with regard to FIPV prevention. We will work with you to identify members of your staff who would be most appropriate to talk with regarding FIPV prevention. The interviews will be informal, private and last 30-60 minutes each. We will not cite the names of people we interview, nor attribute quotes to specific individuals in any reports or presentations. Any member of your staff may refuse to be interviewed or may refuse to answer any questions during the interview without concern. In addition to the interviews, we would like a brief tour of your facility and to receive any materials or information that you use internally or distribute to clients regarding FIPV.
- One member of your staff will be asked to participate in a follow-up telephone interview some time after the visit. The telephone interview will take about 30 minutes and will ask about their knowledge and perceptions of externally developed resources for FIPV

prevention. Answers to these interviews will be confidential. Results will be reported in the aggregate and no individual or clinic names cited in the reports or presentations.

Although we understand that your clinic and your staff already have many responsibilities, Battelle and OPA sincerely hope that you will agree to be part of this study. In the next week or so, I will call you to talk about the study, answer your questions and if you agree, ask for your recommendations about the best individuals to meet with and find a date for the site visit that is agreeable to you.

If you have any questions about the study in the interim, please call me at 703-875-2110 or email me at powersa@battelle.org. Thank you very much in advance for your participation.

Regards,

Anne Powers, Ph.D.
Project Director

B. Informed Consent for Clinic Staff

The Office of Population Affairs (OPA) has asked Battelle Centers for Public Health Research and Evaluation to conduct an in-depth study of family and intimate partner violence prevention activities (FIPV) in nine clinics that provide family planning services. The clinics selected reflect a balance of clinic type, size, location, population served and previous FIPV prevention activities. Your clinic has been selected to be part of this research. In order to learn more about your responsibilities and activities regarding FIPV prevention, as well as the successes and challenges you have experienced with regard to FIPV prevention, we are requesting about an hour and a half of your time.

We are asking for your participation in this interview because you have been identified as a staff member who can provide substantial information about current site operations and characteristics regarding FIPV prevention. Your participation is entirely voluntary. Any information you provide will remain confidential and no one will be able to link you with your responses. Your name will not appear in any reports or documents. You do not have to answer any question that you choose not to and if at any time during this interview you want to stop, please say so and we will conclude the interview.

The interview will be audio taped; names and other identifying information will not be included in any transcriptions or reports. Battelle will destroy identifying information and will permanently erase all tapes upon completion of the analysis.

If you have any questions or concerns about this study, please contact Anne Powers, Project Leader at 703-875-2110.

If you have any questions about your rights as a research participant, please contact Dr. Margaret Pennybacker, Chair of the IRB at 1-877-810-9530, ext 500. You will be given a copy of this form for your records.

I have read this consent form, and I agree to be interviewed about my experiences as a clinic staff member regarding family and intimate partner violence prevention activities.

_____ _____

Interviewee Signature Date

_____ _____

Interviewer Signature Date

C.1 Clinic Director/Manager Interview

(Time: Approximately 90 minutes)

Notes to Interviewers: Explain that you (the speaker) will be primarily conducting the interview and that your colleague will be taking notes and working the tape recorder. Request permission to tape the interview. Explain that tapes will be transcribed and destroyed and that transcripts will only be used for summary and analysis. Explain that they can refuse to answer any questions and that they can end the interview at any time if they choose.

Turn on tape recorder.

Opening:

Tell me a little about the clinic. For example, what services does the clinic offer?

Follow-up: How big is the staff?
Who are your clients? Probe for age, SES, education, ethnicity of clients.
How many clients does the clinic see in a month?

What are your hours of operation?

What is your annual budget?

Please tell me about your job here at [*name of clinic*].

Probe for length of time employed, job title, % time worked, responsibilities.

If Director indicates they see clients: How many clients do you see in an average week?

FIPV Prevention Activities:

Let's talk now about your clinic's activities regarding family and intimate partner violence prevention. What's the overall approach to FIPV prevention?

Can you describe how the FIPV screening fits into the "patient flow" for a routine visit?

Probe for process of FIPV screening, identification and referral. Identify when and how often women are screened as well as how (method) and where screening takes place – specifically whether screening occurs only at intake or during subsequent visits.
Probe for how clinic staff works together to identify FIPV.

[NOTE: COLLECT SCREENING MATERIALS OR GUIDELINES IF WRITTEN.]

What are your personal responsibilities regarding FIPV prevention activities in the clinic?

Who gets screened? Are there specific criteria that suggest someone should be screened or approached?

Follow-up: Is screening conducted by more than one person during same visit?

Is screening repeated at subsequent visits?
Are there any predictors or risk factors that your staff is trained to notice or pay particular attention to? What are those?

Has the clinic changed its screening procedures from when the clinic began to do FIPV screening? If yes, *Why did you make this change?*
What steps are taken to protect the privacy of the client as it relates to FIPV?

Aside from screening, what other procedures does the clinic undertake or methods does your staff use to identify women who are experiencing (or are at risk for) FIPV?
Provide examples if needed: posters and flyers posted in clinic, special events, public education.
If any are identified, *probe to get a full description.*

What kinds of patient education materials do you have?
Probe for use, type and availability to clients.

Follow-up: *Of these materials, which ones are most helpful?*
Which ones do the client's respond best to?

What are the procedures when a women is identified as experiencing FIPV?
Probe for counseling and referral activities including who conducts them and what occurs when a women is identified as experiencing FIPV?

What about follow-up with women identified either as at risk for FIPV or a suspected case of FIPV? Is there some type of counseling or referral for these women?

Does the clinic maintain some type of tracking log or monitoring system for cases reported or referred so that you have a sense of the number of cases?

What happens in the case where you strongly suspect FIPV but do not get an admission from the client?

Does your clinic conduct FIPV screening with minors? If yes, *what special considerations are given in this case? In what way are procedures different?*

What are the reporting requirements in {the state} if you find evidence of FIPV?
Probe to determine requirements for adult women and minors.

FIPV Policies and Protocols:

Does your clinic have a formal protocol or guidelines for clinicians to follow?
If no, How did the process that the clinic is following with regard to FIPV evolve?
Has your clinic's approach to FIPV prevention changed since it began to do FIPV prevention?
Do you anticipate any changes in the near future? If yes, *probe for what changes may occur and why?*

If yes, Describe the protocol or guideline. What's included?
Follow-up: Are their tools included? Resources for referral?

When did you start using this protocol or guideline?
Was it something you developed or did you locate the guideline or protocol from another source?

If another source, *where did you learn about it? Did you modify it upon adoption?*
If developed, *probe for the development process (e.g., piloting, incremental implementation)*

Was there some event or activity that was responsible for developing or seeking out a protocol?

How has the protocol or guideline changed since you first started?

Do you anticipate any changes in the near future?

Training:

Let's talk a bit about training of clinicians and other staff. How is the clinic staff trained in FIPV prevention.
Probe for length and frequency. Determine the format and content.

{Ask these questions only if appropriate.}

Is the training program based on a formal curriculum? If yes, *did you develop it here or was it based on an existing curriculum or program?*
If based on another program, *how did you identify the curriculum?*

Who receives the training?
Probe: Is there selection criteria or a prerequisite of some type?

Are there updates provided?
Probe for how often and in what manner updates are given.

Has the training program changed since its inception?
If yes, *probe for what the changes are and why they were made?*

Do you have a sense of how much the training program costs, in terms of money, time, staff or resources? Do you have a budget for this activity?

What barriers or challenges did you encounter in developing and implementing the training program? How did you overcome these?

What additional materials or resources do you think would benefit your training program?

Probe for whether they've tried to find the materials or resources but have not been able to locate.

Aside from the training, what other resources does your staff rely on with regard to FIPV prevention?

Collaboration with Community Organizations:

Is your clinic part of a community coalition that addresses FIPV?
If yes, *probe to obtain full description of objectives, activities, members, etc.*

Does your clinic or staff collaborate with any community organizations regarding FIPV?

If no, *why not? Have you in the past?*
If yes, *what organizations? Why has this discontinued*?

If yes, *what organizations is your clinic collaborating with?*

How do you collaborate with these (this) organization(s)?
Probe for activities, events, sharing of resources, space, etc.

How long have these collaborations been ongoing?

What's been challenging about these collaborations? What's the most beneficial thing about them?

Are there other organizations you'd like to collaborate with but do not currently?
Probe for reasons why they aren't collaborating with this (these) organization(s)

Resources:

Let's talk about the resources required to implement the FIPV prevention activities.

Do you have a sense of the monetary cost of the FIPV prevention activities? Is there a budget item for any of them?
Follow-up: How are they funded?

What about cost in terms of other resources beyond money such as staff time and resources or clinic space?

What is the impact of the FIPV program on these resources?

Are the present resources enough for continuation of the FIPV prevention activities?
Follow-up: What other prevention activities would you undertake if resources were not an issue?

Closing:

What do you think is the overall impact of these activities on your organization?
Probe for management issues or response from clients.

Follow-up: *What about the impact on your staff?*
What about the impact on you and your responsibilities?

Has the clinic's FIPV program ever been evaluated? Either formally or informally?
If yes, *obtain description and results.*

How could the clinic better meet the needs of at-risk clients?

What's been the most challenging thing about the FIPV prevention activities that your clinic's undertaken? What's the most rewarding?

Looking back on your experiences, how would you change either the planning, approach or implementation to make things easier or better for your clinic?

Follow-up: *What else would you like to do in this area that you haven't been able to implement?*
What's prevented you from doing so?

Thank you very much for your time. Are there any other comments you'd like to make before we end the interview?

C.2 Clinician/Social Worker Interview

(Time: Approximately 60 minutes)

Notes to Interviewers: Explain that you (the speaker) will be primarily conducting the interview and that your colleague will be taking notes and working the tape recorder. Request permission to tape the interview. Explain that tapes will be transcribed and destroyed and that transcripts will only be used for summary and analysis. Explain that they can refuse to answer any questions and that they can end the interview at any time if they choose.

Turn on tape recorder.

Opening:

Tell me a little about the clinic. For example, what services does the clinic offer?
Follow-up: Who are your clients? Probe for age, SES, education, ethnicity of clients.

What are your hours of operation?

Please tell me about your job here at [*name of clinic*].
Probe for length of time employed, job title, % time worked, responsibilities.

In an average week, how many patients do you see?

FIPV Prevention Activities:

Let's talk now about your clinic's activities regarding family and intimate partner violence prevention. What's the overall approach to FIPV prevention?

Can you describe how the FIPV screening fits into the "patient flow" for a routine visit?
Probe for process of FIPV screening, identification and referral. Identify when and how often women are screened as well as how (method) and where screening takes place – specifically whether screening occurs only at intake or during subsequent visits.
Probe for how clinic staff works together to identify FIPV.

What are your responsibilities regarding FIPV prevention activities in the clinic?

Aside from screening, what other procedures or methods does the clinic use to identify women who are experiencing (or are at risk for) FIPV?
Provide examples if needed: posters and flyers posted in clinic, special events, public education.
If any are identified, *probe to get a full description.*

What kinds of patient education materials do you have?
Probe for use, type and availability to clients.

Follow-up: Of these materials, which ones are most helpful?
Which ones do the client's respond best to?

What are the procedures when a women is identified as experiencing FIPV?
Probe for counseling and referral activities including who conducts them and what occurs if a women is identified as experiencing FIPV.

What steps are taken to protect the privacy of the client as it relates to FIPV?

What happens in the case where you strongly suspect FIPV but do not get an admission from the women?

Do you conduct FIPV screening with minors?
If yes, *what special considerations are given in this case? In what way are the procedures different?*

How have your clients reacted to the clinic's FIPV prevention activities?
Probe for reaction to screening, education, follow-up and referral.

FIPV Policies and Protocols:

Does your organization have a formal protocol or guidelines for you to follow?
If no, *How did the process that you're following with regard to FIPV evolve?*
Has your approach to FIPV prevention changed since you started?
Do you anticipate any changes in the near future?

If yes, Describe the protocol or guideline. What's included?
Follow-up: Are their tools included? Resources for referral?

When did you start using this protocol or guideline?
How has the protocol or guideline changed since you first started?

Training:

Have you received any formal training with regard to FIPV?
If yes, *probe for length, frequency and source. Determine the format and content.*

If yes, *in what ways do you update your training and information about FIPV?*

What resources do you rely on to help you with your responsibilities related to FIPV?

What additional materials, resources or training would help you undertake your FIPV prevention activities better?
Provide examples to illustrate: Flyers and brochures for clients, new screening materials, materials to help train new clinicians.
Probe for whether they've tried to find the materials, resources or training but have not been able to locate.

Closing:

What do you think is the overall impact of these activities on you and your responsibilities?
Follow-up: What's been the impact on your professional development?

How has your clinic's FIPV prevention activities changed your job?
Probe for whether the change is for better or worse.

What's been the most challenging thing about the FIPV prevention activities that your clinic's undertaken? What's the most rewarding?

Looking back on your experiences, how would you change either the planning, approach or implementation to make things easier or better for you or your clinic?

How could the clinic better meet the needs of at-risk clients?

Thank you very much for your time. Are there any other comments you'd like to make before we end the interview?

D. Observation Guide

Directions: Use this guide to record your observations of the clinic and the process for the FIPV screening walk through. Each site visitor should independently complete this form and reconcile into one document upon returning from the site visit.

Site Tour

Description of Facilities: For each room/area in the clinic where clients may go, write a description. The rooms include, but are not limited, the waiting area, intake rooms, exam rooms, and the restroom.

Type of Room and Location	Size and Number	Ambiance and Privacy	Presence of FIPV Materials

Other Site Tour Notes:

FIPV Walk Through

Screening: Describe the FIPV screening process in a step by step way. For each step, include the method or format (verbal or written), include where it occurs, when it occurs, with who present (both in terms of clinic staff and anyone accompanying the client), and how long it takes.

Referral: Describe the referral process, i.e., what happens after a women is identified as experiencing FIPV, including how the referral is done, who makes the referral, where it occurs, who is present, how long it takes, and whether there is follow-up after the visit. If so, please describe.

E. Materials Collected from Sites

Appendix E. Materials Collected From Sites						
Region	**Type**	**Title**	**Produced by**	**Intended Audience**	**Description/Contents**	**Size**
I	Staff Manual	{Information for health care providers}	{CLINIC}	Care providers	Protocol; legal provisions; indicators of domestic abuse; clinical history forms including items related to physical, sexual, emotional abuse, abandonment, and neglect;; toll-free hotline numbers; safety plans; "A Safe Place" brochures	traditional notebook
I	Brochure	Caring Unlimited	{COUNTY} County	General public	Power and control wheel, definition of domestic violence, safety planning, services, mission, how you can help, contact information with toll-free hotline	3-panel back and front; 11 x 8 1/2"
I	Brochure	Healthcare with Roots in Your Community	{CLINIC}	General public	Programs, focus, services, description of clinic	3-panel back and front; 11 x 8 1/2"
I	Brochure	Sexual Assault Support Services	Sexual Assault Support Services	General public	Services, prevention education, volunteer opportunities, what to do if you're sexually assaulted with toll-free telephone number	bifold with pockets for inserts, 8 1/2 x 3 3/4"
I	Brochure	Domestic Violence Safety Plan	A Safe Place	Victims	What to do during a violent incident, when preparing to leave, while living apart from partner, when you have a protective order, at your job and in public, other concerns, checklist of things to take; contact information with toll-free hotline	3-panel back and front; 11 x 8 1/2"
I	Brochure	Healthy Relationships: What Do I Deserve?	A Safe Place	Victims	Power and control wheel, equality wheel, tips on conflict, personal rights and responsibilities, resources, contact information with toll-free hotline number	3-panel back and front; 11 x 8 1/2"
I	Posting	Support Offered by A Safe Place	A Safe Place	Victims	Description of community safe place	8 1/2 x 11" sheet with tear-offs containing hotline number along bottom
I	Brochure	Are You in Danger of Sexual Assault	Sexual Assault Support Services	Victims and friends of victims	Warning signs of sexual assault, safety issues, toll-free telephone number and other contact information	2-panel front and back 11 x 8 1/2"

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
I	Brochure	How To Be A Real Friend and Deal with Dating Violence	seeitandstopit.org	Youth	What is dating violence, what you can do about it, warning signs, how to make a difference,	5-panel, one-sided, folds to size of CD (5 x 4 3/4")
I	Bookmark	If Your relationship is scary or confusing you can reach out	A Safe Place	Youth	Toll-free hotline number	bookmark
I	Bookmark	You Don't Have To Be In Crisis To Call Us	A Safe Place	Youth	Toll-free hotline number	bookmark
II	Staff Manual	Community Healthcare Network Social Work Dept. Policy and Procedure Manual	Community Healthcare Network	Care providers	Responsibilities, procedures related to screening, identifying victims through observation, chart documentation, interventions	six 8 1/2 x 11" pages
II	Handout	Cycle of Violence		Care providers	Illustrates cycle of violence from rising tension to battering incident to seduction phase, with corresponding behaviors for victim and batterer	8 1/2 x 11" sheet
II	Handout	History of Case: Stacey and Thomas		Care providers	Case history of escalating abuse	8 1/2 x 11" sheet
II	Handout	{Difference between violent and non-violent relationships}	Domestic Abuse Intervention Project, Duluth, MN	General public	Two wheel diagrams, one representing beliefs and behaviors in non violent relationships, the other corresponding to violent relationships	two 8 1/2 x 11" sheets
II	Handout	Domestic Violence	not listed	General public	Definition of domestic violence, subtypes of domestic violence, facts	8 1/2 x 11" sheet
II	Handout	Domestic Violence: Getting Help		General public	Lists 4 sources of help (police, courts, social services, advocates and lawyers) and how each can be of assistance	8 1/2 x 11" sheet
II	Handout	Domestic Violence: Power & Control Through Coercive Behaviors		General public	Lists 4 types of domestic violence (physical, emotional, sexual, and economic) and behaviors that correspond to each	8 1/2 x 11" sheet
II	Handout	Red Flags of Abusive Behavior	Safe Horizon Domestic Violence Police Program	General public	List of abusive behaviors, warning signs for abusive relationships	8 1/2 x 11" sheet
II	Handout	The Escalating Course of Domestic Violence		General public	Facts about domestic violence including a table showing its escalating nature with fear increasing and hope decreasing	8 1/2 x 11" sheet
II	Handout	Why Victims Stay: Obstacles to Leaving		General public	Lists 4 main reasons why people stay in abusive relationships (practical, emotional, social, and relationship factors) with specific examples of each	8 1/2 x 11" sheet
II	Handout	Emotional First Aid	{HOSPITAL} Sexual Assault and Violence Intervention Program (SAVI)	Rape victims	Guide to recovery from a rape survivor; 24 bulleted points to remember after a rape with SAVI telephone number (not toll free)	8 1/2 x 11" sheet

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
II	Handout	Primeros Auxilios Emocionales Para Mujeres	{HOSPITAL} Sexual Assault and Violence Intervention Program (SAVI)	Rape victims	Guide to recovery from a rape survivor; 24 bulleted points to remember after a rape with SAVI telephone number (not toll free)	8 1/2 x 11" sheet
II	Handout	Reacciones Comunes a la Violacion	{HOSPITAL} Sexual Assault and Violence Intervention Program (SAVI)	Rape victims	List of 15 common victim reactions to rape	8 1/2 x 11" sheet
II	Handout	Myths and Facts About Domestic Violence	The Commission on Domestic Violence (www.abanet.org)	Students	Refutes common myths regarding domestic violence and supplies appropriate facts	three 8 1/2 x 11" sheets
II	Handout	Family Violence Hotline	UJA-Federation of {STATE}; Jewish Board of Family and Children's Services, Inc	Victims	Describes services, encourages victims to seek help, provides hotline number (not toll free)	8 1/2 x 11" sheet
II	Brochure	SAVI (Mt. Sinai Sexual Assault and Violence Intervention Program)	{HOSPITAL} Sexual Assault and Violence Intervention Program (SAVI)	Victims	Describes services, encourages victims to seek help, provides hotline number (local and toll free)	3-panel back and front; 11 x 8 1/2"
III	Staff Information	State Laws	{STATE}	Care providers	State laws related to adult protective services, mandatory reporting of abuse, and reporting procedures	three 8 1/2 x 11" sheets
III	Brochure	Board of Health	{CLINIC}	General public	Mission statement, programs, members, staff	3-panel back and front; 11 x 8 1/2"
III	Booklet	County Family Resource Guide	{CLINIC}	General public	Community information and contact information	5 1/2 x 8" booklet, 45 pages
III	Brochure	Farm Resource Center	Farm Resource Center	General public	Goals, description of organizational outreach programs, symptoms of stress, stress busters, contact information with toll-free crisis hotline	3-panel back and front; 11 x 8 1/2"
III	Booklet	Trust Betrayed	{STATE} Coalition Against Domestic Violence	General public	Dynamics of healthy relationships, signs of controlling relationships, how to deal with dating violence, resources, safety plan, contact information for services, including toll-free number	5 1/2 x 8" booklet, 28 pages
III	Handout	Call Hope for Help	Task Force on Domestic Violence	Victims	Services	5 1/2 x 8 1/2 back and front

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
III	Brochure	What Girls Should Know When Dating Hurts	{STATE} Women's Commission, DHHS	Youth	Cycle of violence, talking about it, staying safe, violence is against the law, getting a protective order, facts and danger signs, state resources with contact information	4-panel back and front, 14 x 8 1/2"
IV	Booklet	About Family Violence	Scriptographic	General public	Definition of family violence, types of family violence, and other information about family violence	6 1/2 x 8" booklet, 15 pages
IV	Brochure	County Board of Health Services	{CLINIC}	General public	Services, health promotion and prevention, with local contact information	3-panel back and front; 11 x 8 1/2"
IV	Brochure	Departamento de Salud del Condado de Douglas	{CLINIC}	General public	Services, health promotion and prevention, with local contact information (Spanish)	3-panel back and front; 11 x 8 1/2"
IV	Posting	Domestic Violence is Everyone's Business		General public	Crisis hotline number and description	8 1/2 x 11" sheet
IV	Handout	Share House?		Victims	Services offered at shelter, contact information with local telephone number	8 1/2 x 11" sheet
V	Form	Female Medical Visit	{CLINIC}	Care providers	Checklist of problems for physician/caregiver to discuss with female patient including sexual coercion	8 1/2 x 11" sheet, double-sided
V	Form	Medical History-Initial Visit	{CLINIC}	Care providers	Checklist of problems for physician/caregiver to discuss with female patient including sexual abuse or domestic violence	8 1/2 x 11" sheet, double-sided
V	Form	Social History-OB Visit	{CLINIC}	Care providers	Checklist of problems for physician/caregiver to discuss with pregnant female patient including physical and sexual abuse	8 1/2 x 11" sheet, double-sided
V	Brochure	Always Here for You...	{CLINIC}	General public	Services related to health care, advocacy, education, and professional training	3-panel back and front; 11 x 8 1/2"
V	Handout	Domestic Violence Referral Sheet	{CLINIC}	Victims	List of 6 organizations that provide services to victims in 3 counties	8 1/2 x 11" sheet
V	Brochure	Just the FAQs	{COUNTY} County Children's Services	Victims	Description of Children's Services, hotline for reporting neglect or abuse, what happens to kids who are removed from their families, information about foster and adoptive parenting	photocopy of brochure: 3-panel back and front; 11 x 8 1/2"

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
V	Brochure	{STATE} Domestic Violence Network	{STATE} Domestic Violence Network	Victims	Description of organization, services, program, and shelter contact information with toll-free numbers	photocopy of brochure: 3-panel back and front; 11 x 8 1/2"
V	Brochure	YWCA Rape Crisis Center	YWCA Rape Crisis Center	Victims	Services, How Family and Friends Can Help, What Should a Survivor Do, Reactions, hotline number (not toll free)	3-panel back and front; 11 x 8 1/2"
V	Brochure	Domestic Violence: Taking Action	{STATE} Dept of Health	Victims and perpetrators of DV	Power and control wheel, information about domestic violence, domestic violence behaviors, many {STATE} contacts for help	photocopy of brochure: 3-panel back and front; 11 x 8 1/2"
V	Brochure	10 Things You Need to Know Before You Date an Older Guy...Consider the Risks	{CLINIC}	Youth	10 Things to Consider if dating a guy 4 or more years older than you	3-panel back and front; 11 x 8 1/2"
V	Brochure	Dating Violence: Teens Talk with Teens	www.etr.org	Youth	Describes violent dating scenario, interjecting facts about dating violence, ways to avoid dating violence, no contact information or hotline number	4-panel back and front, 14 x 8 1/2"
V	Brochure	Teens...and Dating Violence	{STATE} Office of Criminal Justice Services/Family Violence Prevention Center	Youth	Definition of teen dating violence, statistics and information, test to determine if relationship is abusive, contact information for services including toll-free number	photocopy of brochure: 3-panel back and front; 11 x 8 1/2"
VI	Booklet	About Being a Father	Scriptographic	Fathers	Discusses role of father in child's life; provides examples of positive father behaviors	5 1/2 x 8" booklet, 15 pages
VI	Brochure	Esperanza House	Esperanza House	General public	Mission, goals, and programs	3-panel back and front; 11 x 8 1/2"
VI	Form	Client Physical Exam		Care providers	Physical findings, assessments, plans	8 1/2 x 11" sheet
VI	Form	Current Medical History	{CLINIC}	Care providers	Patient history form	two 8 1/2 x 11" sheets
VI	Form	Domestic Violence Screening/Documentation Form	{CLINIC}	Care providers	Diagram of female body to show injuries, patient safety assessment, documentation for referrals, reporting and photographs	8 1/2 x 11" sheet

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
VI	Booklet	Are You a Single Parent? – You Are Not Alone	Scriptographic	Parents	Tips for single parenting	6 1/2 x 8" booklet, 7 pages
VI	Booklet/folder	Beginnings: Families FIRST (Families and Infants Receive Services and Training)	Practical Development, Inc	Mothers	Folder that contains inserts related to pregnancy, infant development, caring for infants; printed flap contains warning signs for problems during pregnancy	folder when closed is 9x6"
VI	Form	Client Health History		Patients	Health questions including physical and sexual abuse	two 8 1/2 x 11" sheets
VI	Brochure	Concerned About Your Relationship?	Family Violence Prevention Fund	Victims	Facts about domestic violence, what to do, local and toll-free numbers for hotlines	3-panel back and front; 14 x 8 1/2"
VI	Card/handout	Domestic Violence	Resources, Inc	Victims	Contact information for free legal information, domestic violence victim safety plan, questions to help victims identify abusive relationships, toll-free hotline numbers	8 1/2 x 3 1/2"
VI	Brochure	Preocupada por su Relaccion?	Family Violence Prevention Fund	Victims	Facts about domestic violence, what to do, local and toll-free numbers for hotlines	3-panel back and front; 14 x 8 1/2"
VI	Brochure	{CITY} Refuge for Battered Adults	{CITY} Refuge for Battered Adults	Victims	Facts, checklist of signs of abuse, services offered	3-panel back and front; 11 x 8 1/2"
VI	Brochure	Usted Tiene Derecho de Vivir Libre de Violencia en su Hogar	Family Violence Prevention Fund	Victims	Especially for immigrants and illegal aliens: What is domestic violence, what victims can do to be safe, getting a restraining order, calling the police; local and toll-free numbers (Spanish)	4-panel back and front, 14 x 8 1/2"
VII	Brochure	If Someone In Your Life is Sexually Assaulted: A Guide for Friends and Families of Victims	{CITY} Area Sexual Assault Center	General public	Definition of sexual assault; psychological responses; how to help; message for partners; contact information including crisis hotline number (not toll free)	3-panel back and front; 11 x 8 1/2"
VII	Brochure	Help End Domestic Violence	YWCA of {CITY}	General public	Definition of and facts about domestic violence, ways to join the effort against domestic violence, contacts for assistance (national toll-free hotline and state-level women's crisis centers/safehouse telephone number and services)	3-panel back and front; 11 x 8 1/2"

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
VII	Brochure	Women's Crisis Center & Safehouse: An Empowering Program for Victims of Domestic Violence	YWCA of {CITY}	General public	domestic violence statistics, steps for leaving an abusive situation, if someone you know is being abused, mission statement of Y, crisis center services information, enclosure for contribution, SAFE (local shelter) telephone number	4-panel back and front, 1/2 sheet; approx 17.25" x 7"
VII	Worksheet	Worksheet: Warning Signals		Victims	Presents 15 behaviors and asks what person would do in each (do nothing, discuss, try to change, end relationship)	8 1/2 x 11" sheet
VII	Worksheet	Unequal Relationships Have Unequal Power and Control		Victims and perpetrators of DV	Lists signs of unequal relationships and specific behavior under each heading. Also characteristics of healthy relationships and their corresponding behaviors	two 8 1/2 x 11" sheets
VII	Business card	{CITY} Area Sexual Assault Center	{CITY} Area Sexual Assault Center	General public	Counseling, education, and prevention services and contact information with crisis hotline number (not toll free)	3 1/2 x 2" card
VII	Worksheet	Worksheet: Sexual Behavior Attitude Survey	not mentioned	Victims and perpetrators of DV	Lists 11 sexual beliefs and asks respondent to describe level of agreement on a 3-point scale	8 1/2 x 11" sheet
VII	Brochure	Breaking the Silence of Child Sexual Abuse: A Guide for Parents	{CITY} Area Sexual Assault Center	Parents	Indicators of child sexual abuse, myths and facts, things to teach children, contact information including crisis hotline number (not toll free)	3-panel back and front; 11 x 8 1/2"
VII	Brochure	Date Rape: Ten Things You Can Do To Protect Yourself	Journeyworks Publishing	Youth	List of 10 protective measures with bulleted suggestions for each; no contact information or crisis hotline number	3-panel back and front; 11 x 8 1/2"
VII	Brochure	Domestic Violence	www.etr.org	Victims	What is domestic violence, warning signs, making a plan, where to get help, what to do, has the batterer changed, no hotline number	4 double panels back and front, opens to 17 x14"
VII	Brochure	Immediate Help for Victims of Sexual Assault	{CITY} Area Sexual Assault Center	Victims	Explanation of medical exam, medical follow-up, reporting to police, investigating the assault, court proceedings, services of sexual assault center, feelings, support groups, contact information including hotline number (not toll free)	4-panel back and front, 14 x 8 1/2"
X	Form	{STATE} Maternity Case Management Individual Client Support Plan	{CLINIC}	Case manager	Form to record client and case manager information and plans	8 1/2 x 11" sheet
X	Brochure	Acquaintance Rape	www.etr.org	General public	Definition of acquaintance rape, risk factors, warning signs, what to do about acquaintance rape, and reducing the risk	4-panel back and front, 14 x 8 1/2"

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
X	Brochure	Drinking and Violence	www.etr.org	General public	Drinking-related problems, reducing risk of violence, toll-free referral numbers	3-panel back and front; 11 x 8 1/2"
X	Booklet	Family Violence Hurts Children	Scriptographic	General public	Identifying kids in violent homes, helping them	5 1/2 x 8" booklet, 15 pages
X	Booklet	Sobre la Violencia en el Hogar	Scriptographic	General public	Definition of family violence, types of family violence, and other information about family violence (Spanish)	6 1/2 x 8" booklet, 15 pages
X	Booklet	Parenting – It Takes Love	Scriptographic	Parents	Parenting tips	5 1/2 x 8" booklet, 15 pages
X	Handout	When a Crying Baby Is More Than You Can Handle...	Children's Services Division/ Children's Trust Fund of {STATE}	Parents	Tips for handling stress of crying baby with toll-free hotline number	8 x 3 1/2" back and front
X	Handout	When Anger Pushes You to the Edge...	Children's Services Division	Parents	Anger management tips with toll-free hotline number	8 x 3 1/2" back and front
X	Brochure	Concerned About Your Relationship?	Family Violence Prevention Fund	Victims	Facts about domestic violence, what to do, local and toll-free numbers for hotlines	3-panel back and front; 14 x 8 1/2"
X	Brochure	Domestic Violence: Getting Out	www.etr.org	Victims	Safety planning, talking with kids	4-panel back and front, 14 x 8 1/2"
X	Brochure	Promoting Healthy Communities	Asante Health System	Victims	Lists support services available, with staff contact information	3-panel back and front; 12 x9"
X	Pocket-sized brochure	{STATE} Family Violence Referrals	{STATE} Medical Association	Victims	Contact information for services, including toll-free numbers; options for protection through legal system	pocketsized, bifold front and back, closed 2 x 3 1/2"
X	Brochure	Are You Feeling Alone, Scared and Abused in Your Own Home?	{STATE} Valley Safe House Alliance	Victims	Complete safety plan, list of abusive behaviors, contact information for support services, including toll-free numbers	pocketsized: 3-panel back and front; 5 3/4 x 3 3/4"
X	Brochure	Love Shouldn't Hurt	{STATE} Dept. of Human Services/ Health Division	Victims	Definition of domestic violence, examples of violent behaviors, making a safety plan, extensive list of community resources with toll-free numbers	3-panel back and front; 14 x 8 1/2"

Appendix E. Materials Collected From Sites

Region	Type	Title	Produced by	Intended Audience	Description/Contents	Size
X	Brochure	No One Deserves Domestic Abuse	Three Rivers Community Hospital	Victims and friends of victims	What is domestic violence, warning signs, legal remedies, how to help a friend who is being abused, resources including toll-free numbers	3-panel back and front; 12 x9"

F. Short Interview Codebook

Node	Node Title	Long Definition
1	Background	
1 1	Interviewee Background	Any background pertaining to the interviewee
1 2	Clinic Background	
1 2 1	Facility Background	Background about the facility
1 2 2	Patient Background	Patient Characteristics
1 2 3	Staff Background	Characteristics of clinic staff
2	Clinic's Role in FIPV	Respondent's description of what clinics should be doing around FIPV
3	Priority	Respondent's assessment of the priority that FIPV activities take in the clinic
4	Model/Ideal Program	
4 1	Model Training Program	Description of ideal training program
4 2	Model FIPV Program	Ideal program would include these activities
5	Current Program	Description of current program
5 1	Screening	
5 2	Materials	
5 3	Referral and follow-up activities	
5 4	Outreach and collaborations	
5 5	Resources	
5 6	Evaluation	Evaluation activities as well as results of evaluations
5 7	Training	
5 8	Education	Education provided to women in clinic that does not have a materials component
6	Barriers/Challenges	
6 1	Training Barriers/Challenges	Barriers/challenges to training staff in FIPV
6 2	Program Barriers/Challenges	Barriers/challenges to implementing FIPV program activities
7	Needs/Wants	
7 1	Training needs/wants	Needs/wants for training. Must explicitly say that is what they want.
7 2	Program needs/wants	Needs/wants for program. Must explicitly say that is what they want.
8	No. 1 problem	Explicit response to question asking respondent to identify number one problem
9	Policies	Policies or guidelines followed by the clinic
10	Minors	Anything discussed about FIPV programming, training, or policies referring to minors

Review of Family and Intimate Partner Violence Prevention: Reproductive Health and Clinical Issues

For the Project:

A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Title X-funded Family Planning Clinics
Contract Number 282-98-0019
Task Order 13

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1.0 Introduction

Battelle Centers for Public Health Research and Evaluation conducted a literature review as one component of the project *A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Title X-funded Family Planning Clinics* under contract with the Office of Population Affairs (OPA). The goal of this project is to identify promising practices in family and intimate partner violence (FIPV) prevention for family planning clinics and clinicians. Findings from this literature review will be combined with other project efforts – site visits, key informant interviews, and an evaluation of an FIPV resource kit for clinicians – to produce a final report of promising practices in FIPV prevention for Title X-funded clinics.

This review encompasses two areas of interest to the project. First, the published literature on FIPV and reproductive health is reviewed with an emphasis on clinical issues and the role of clinicians in identifying FIPV while providing reproductive health care. In this paper, we focus on the reproductive health topics of pregnancy, contraception including condom use, sexually transmitted diseases (STDs), and human immunodeficiency virus (HIV). Second, we review FIPV prevention in clinical settings including protocols and guidelines, tools for screening and prevention, training programs for clinicians, and evaluated clinical interventions for FIPV prevention. The literature review concludes with areas for further exploration and research.

Literature Review Methods. Articles and papers included in this review are drawn from peer-reviewed publications, other published books and articles, and documents obtained from websites and professional organizations with interests in FIPV. To identify peer-reviewed and published papers, Battelle conducted a literature search of social science and medical literature using the DIALOG search engine that includes Medline®, Psycinfo®, and Social SciResearch®. The initial search used the following terms (note that the "?" is a wild card character allowing variations on a word into the search):

- Intimate partner violence
- Domestic (abuse or violence)
- Battered women (or female)
- (Family, or partner or spous? or marital or wife) abuse

To refine our search to reproductive health topics, results of the above searches were crossed with the following terms:

- Reproductive health
- Prenatal care
- Family planning
- Sex education
- Pregnan?
- Contraception or birth control
- Condom
- HIV prevent(?)
- STD prevent(?)

- OB/GYN care
- Physician? (role or attitude or practice)

The search was limited to the previous six years (1999 through 2004), although a few particularly important documents prior to 1999 are included in the review set. From the initial search, 294 articles were identified. Abstracts from these articles were reviewed and those considered relevant were obtained by Battelle (n=133). Once we were in receipt of the articles, the Project Director made a further decision about the relevance of the paper for the project. Those considered relevant at this stage became part of the literature review set and the references for these were checked for additional articles not previously identified. After reviewing the references and obtaining these documents, the final number of relevant published books and articles was 92. In early 2005, an additional search was conducted to update the literature review. As a result of this search 12 additional articles were identified and obtained.

To identify white papers, guidelines, and protocols available through the internet, an initial list of important websites was developed by the project team. Battelle examined each website for relevant documents to download or order. In addition, we followed links from the initial websites to identify secondary websites of interest. Again these were examined and relevant documents downloaded or ordered. A list of the websites used for the project is included in Appendix A. While not an exhaustive list, these are the major websites containing FIPV research and information. They include professional associations, foundations, coalitions, resource centers and government agencies that make FIPV-related information available on their websites. As a result of this search, 48 documents identified on the internet were obtained to be part of the literature review set. Since the initial search in 2004, an additional 10 documents have been obtained and included in the database. Finally, five documents including presentations and agency documents were obtained at conferences, particularly the Family Violence Prevention Fund's bi-annual conference held in November 2004 in Boston, Massachusetts. In total, 166 documents are included in the literature review set.

Abstracting Documents. Each document that was considered relevant to the literature review was logged into a Microsoft Access database by recording basic bibliographic information about the document. Each document was then read and abstracted by a member of the project team. Information abstracted about each document included: type of document, purpose, content, audience, objectives and, if a research or evaluation article, methods and findings. Each document was given a unique identifying number. Appendix B is a bibliography of the literature contained in the database. Note that each document's unique identifier is cited (in superscript) in the review along with author(s) and year of publication for ease in locating the document in the bibliography.

The following review is based on the documents included in the database, although not all documents included in the database are cited in the review. Section 2.0 reviews the literature in FIPV and reproductive health including pregnancy, contraception and STDs and HIV. Section 3.0 reviews literature and documents intended to help clinicians conduct screening and prevention activities in FIPV including guidelines, protocols, screening instruments, training programs, and evaluated clinical interventions. The review concludes with further considerations in FIPV prevention (Section 4.0) and a summary of our findings from the literature review (Section 5.0).

2.0 Family and Intimate Partner Violence and Reproductive Health

2.1 Pregnancy

Intimate partner violence (IPV) during pregnancy is an area of great concern because physical abuse can result in harm to both mother and child. A child can be hurt directly by violence toward the mother (e.g., blows to the abdomen) resulting in injury to the child, or indirectly through circumstances that lead to preterm delivery, low birth weight, or other birth complications. In this review, we found that violence during pregnancy has probably received more attention than any of the other areas included in this review. However, as noted below, there are several issues that require clarification.

Prevalence of Violence during Pregnancy. Population-based studies indicate that between 4 and 8 percent of women experience physical abuse during pregnancy (Seger, 1998[30]; McFarlane, Parker, Soeken, Silva & Reed, 1999[25]; Torres et al., 2000[47]), although a few studies have shown higher rates (Rachana, Suraiya, Hisham, Abdulaziz & Hai, 2002[14]). Prevalence estimates of IPV overall range from 3 to 20 percent (Rachana et al., 2002[14]). It is a common notion that abuse increases during pregnancy. However, the evidence to support this is mixed. Early studies suggested increased risk of abuse for pregnant women, but this has not generally been supported. It appears more likely that (a) the same underlying factors contribute to a woman's likelihood of abuse and pregnancy (e.g., age), and (b) pregnancy creates an additional trigger for violence in already abusive or potentially abusive relationships. Related to this is the denial of access to contraception experienced by abused women (discussed below) that may increase the risk of an unplanned pregnancy.

Some authors have suggested that the perceived increase in risk of IPV during pregnancy is attributable to other factors associated with these women. For example, Mayer and Liebschutz (1998[28]) suggest that increased risk seen in some studies is likely attributable to the women being of child-bearing age (a known risk factor for violence) but not pregnancy in particular. Among the literature we reviewed, studies identified as showing a higher rate of IPV during pregnancy were often conducted with populations already at risk because of their age, income, education, or risky behavior (Denham, 2003[4]; Espinosa & Osborne, 2002[13]). In addition, some of the evidence supporting the increase comes from qualitative studies of women (e.g., Coggins & Bullock, 2003[3]) that report the results of in-depth interviews or focus groups. These same studies are frequently conducted with low-income, minority women identified through public health clinics, a population already at risk for IPV.

We also identified one study that found a decrease in IPV during pregnancy. In a study with migrant and seasonal farm workers (n=1001) who received care from 11 federally funded migrant health care clinics, Van Hightower, Gorton and DeMoss (2000[64]) found that pregnancy reduced the likelihood of abuse by as much as 65 percent. The authors suggested that for this particular population – which has a generally high rate of IPV – pregnancy is a protective factor against violence, either by abusers internalizing values against victimizing pregnant women or by women who are abused choosing not to become pregnant.

Evidence does suggest that pregnancy can exacerbate abuse or violence in a relationship. McFarlane et al. (1999[25]) conducted a study with 199 pregnant women who had been abused, examining rates of abuse before and during pregnancy. They found that 18 percent reported abuse during pregnancy but not before, 30 percent reported abuse before pregnancy but not during, and 52 percent reported abuse before and during pregnancy. Those women who reported abuse before and during pregnancy also reported greater severity of abuse on all measures (danger assessment, physical, nonphysical, threat and actual).

Despite the lack of consistent evidence that IPV increases with pregnancy independent of other factors, women who are abused during pregnancy are different than women who are not abused. In looking at a sample of newly pregnant women visiting a clinic in Southern California, abused women were more likely to report friends rather than family as their primary support system, fear of their partner, childhood sexual abuse, and depression and anxiety while pregnant (Anderson, Marshak, & Hebbeler, 2002[12]). They were also less likely to report an emotionally supportive partner. In a study of 207 pregnant women, Huth-Bocks, Levendosky & Bogat (2002[19]) found that abused women (n=68) were more likely to use alcohol, drugs, and tobacco while pregnant, and experience depression.

Potential Outcomes of Intimate Partner Violence during Pregnancy. As with the increase in incidence of IPV during pregnancy, there are inconsistent findings regarding the outcomes of experiencing violence while pregnant, but these are not quite as pronounced and a few outcomes can be considered as a highly likely result of violence during pregnancy.

The most frequently identified outcome of IPV during pregnancy appears to be late entry into prenatal care (Mayer & Liebschutz, 1998[28]; Anderson et al., 2002[12]; Huth-Bocks et al., 2002[19]; Seger, 1998[30]). Using data from the Pregnancy Risk Assessment Monitoring System (PRAMS), Seger examined data from more than 27,000 women in nine states. Among the respondents, 4.7 percent reported violence in their relationships and these women were 1.8 times more likely to enter prenatal care late (i.e., during the third trimester).

Inadequate weight gain also appears to be an outcome of experiencing IPV while pregnant (Mayer & Liebschutz, 1998[28]; Anderson et al., 2002[12]; Gazmararian et al., 2000[53]). However, one study found that excessive weight gain was associated with experiencing IPV (Johnson, Hellerstedt, & Pirie, 2002[17]). Johnson et al. conducted a chart review of 578 clients at a prenatal care clinic. Among adults in the sample, women who reported current abuse gained 7 pounds more than women who did not report current abuse, suggesting that while inadequate weight gain may be more common, non-optimal weight gain is perhaps a better indicator of abuse. Excessive weight gain may have fewer implications for the infant and as a result has received less attention. Nevertheless, excessive weight gain may be a useful identifier of women experiencing IPV while pregnant and suggests an area for future research.

Other studies have found an increase in preterm labor (Anderson et al., 2002[12]; Huth-Bocks et al., 2002[19]), miscarriage (Rachana et al., 2002[14]; Huth-Bocks et al., 2002[19]), and placental abruption (Rachana, et al., 2002[14]). Miscarriage and placental abruption are likely associated with blows to the abdomen. Cesarean sections (Rachana et al., 2002[14]) and longer hospital stays have also been associated with experiencing IPV during pregnancy (Huth-Bocks et al., 2002[19]).

However, there does not seem to be support for differences in number of weeks at delivery or birth complications (Huth-Bocks et al., 2002[19]).

It is worth noting that the two most commonly found outcomes of abuse during pregnancy – late entry into prenatal care and inadequate weight gain while pregnant – have serious implications for the infant. The most frequently found infant outcome is low birth weight (Anderson et al., 2002[12]; Mayer & Liebschutz, 1998[28]).

Current Issues. Two issues stand out as pressing in our review. First, further research is needed to determine how some of the distinguishing factors between abused and non-abused women during pregnancy are related to pregnancy. Prospective studies with abused and non-abused women identified before pregnancy and followed through their pregnancy would help to explain the relationships. For example, depression is associated with abuse during pregnancy but the evidence is somewhat unclear as to whether depression is a risk factor for abuse during pregnancy, a result of experiencing abuse while pregnant, or part of a syndrome of conditions that co-occur within the context of abuse during pregnancy.

Second, qualitative and anecdotal evidence from providers suggests that they believe abuse increases or becomes more likely during pregnancy but most studies do not support this. Although there may be numerous reasons for the perceived increase, there are three that seem likely. First, pregnancy may be the first time that some women seek medical care and thus their first interaction with a caring health care provider. This is supported by the late entry into prenatal care that is more likely with women in abusive relationships. Second, pregnancy is a time when providers and patients have long-term and repeated interactions, increasing the possibility that previously unreported abuse is identified. Evidence suggests that violence may be reported during subsequent screening that was initially denied (Glander et al., 1998 as cited in Campbell, Woods, Chouaf, & Parker 2000[46]). Finally, pregnancy may be a trigger for women to report longstanding abuse because of their fears for their child's safety.

Role of the Clinician. Pregnancy can be an excellent opportunity to identify women experiencing violence in their relationships and help them seek relief from the abuse. The nature of prenatal care promotes the development of a close, regular, and trusting relationship (American Medical Association guidelines). Visits during pregnancy and after birth provide opportunities for frequent and repeated screenings (Anderson et al., 2002[12]). Pregnancy also provides more opportunities to help women leave abusive situations because of the additional support services available to women while pregnant (Mayer & Liebschutz, 1998[28]).

Because of the increased interactions with patients occurring during pregnancy, clinicians can use the opportunity to identify previously undetected violence. All of the following might suggest abuse:

- Late entry into care or treatment delay as discussed earlier.
- Suspicious patterns of injuries particularly to the face, breast, and abdomen. Pregnant women tend to fall backward so injuries on the front of the body are unusual (Saunders, 2000[48]). Injuries to hands and outer arms are also suspicious because they often occur in self-defense.
- Indicators of poor self-care and autonomy specific to pregnancy such as choice about whether to conceive, responsible use of contraception, appropriate nutritional intake and

weight gain during pregnancy, grooming, participation and follow-through on medical advice and treatment, and preparation for childbirth and parenting (Mayer & Liebschutz, 1998[28]).

2.2 Contraception

Scope of the Problem. Although hormonal and other non-coital dependent methods are considered in a few studies we reviewed, much of the research on contraceptive use in women experiencing IPV has focused on condom use. For this reason, our emphasis is primarily on condoms as a birth control method. In general, results in regard to condom use are reasonably consistent – women in abusive relationships are less likely to ask for and use condoms. In one study that incorporated hormonal methods, Rickert, Wiemann, Harrykissoon, Berenson and Kolb (2002[16]) found similar results with hormonal methods – non-use at last intercourse was 50 percent more likely in relationships with physical or verbal abuse. The remaining studies discussed in this section focus on condoms.

In an often-cited study, Wingood and DiClemente (1997[156]) reported that African-American women in abusive relationships were less likely to ask for condoms and that this resulted in higher rates of STDs and unplanned pregnancies. Another study with sexually coerced women found that they were marginally less likely to use condoms at last sex out of fear that the request would lead to a violent episode ("being hit", Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998[68]). In the same study, significantly more non-coerced women reported that their partner used a condom when asked during last sex.

These findings hold up even in HIV-positive relationships. In a study of 611 women (310 HIV-positive and 301 HIV-negative), those in seriously violent relationships – defined as 13 or more violent episodes per month – were less likely to request that a condom be used (Gielen, McDonnell, & O'Campo, 2002[60]). Another study of women recruited from an outpatient HIV/AIDS clinic (166 HIV-positive women) and a similar group of women recruited from community organizations (199 HIV-negative women) found that condom use was less likely to be used in abusive relationships regardless of the HIV status of the women (Gielen, McDonnell, O'Campo, & Burke, 1999[132]).

Focus groups of battered women participating in an outreach support group conducted by Coggins and Bullock (2003[3]) provides some interesting insights and may help to explain why contraception is less likely to be used in violent relationships. These women were asked about using contraception within the context of an abusive relationship. Control and fidelity were themes in these focus groups. These women reported that the men who abused them wanted to control contraception within the relationship as a way to exert power and control over their partner. In addition, the violent men believed the women would have extramarital sex if they had access to birth control. These same women also reported their belief that asking for birth control or condoms would lead to violence, so they typically avoided asking for birth control, leaving them at risk for unplanned pregnancies. In another qualitative study of Mexican and Mexican-American women, a request for condom use was seen as a breach of trust within the relationship – suggesting infidelity by either the man or woman (Davila & Brackley, 1999[57]). In this population, requests for condoms were value laden and associated with extramarital or casual sex. Requests were often followed by accusations of having a disease or a boyfriend on the side.

Infidelity appears to be a key factor in condom use in violent relationships. A study of Hispanic women in abusive relationships found that the women did not request condoms be used because they feared that their partner would then be unfaithful to them (Raj, Silverman & Amano, 2004[168]) as a result. Neighbors and O'Leary (2003[165]) conducted a study with men incarcerated in a county jail. The men were asked to read several scenarios about a woman asking her partner to use condoms. Men's responses showed that the scenarios could be grouped into high and low relationship-threat circumstances. The most threatening scenarios involved the suggestion of infidelity on the part of the women. In addition, the men's level of self-reported violence in their current relationship predicted more coercive responses to those scenarios suggesting the woman's infidelity.

Role of the Clinician. Several findings in the relationship between contraception and IPV can help clinicians identify violent relationships. In particular, a clinician should consider carefully why a woman is not using contraception if she reports this during a visit (Rickert et al., 2002[16]). A women not using contraception but not intending to become pregnant may be in a situation where access is being denied by an abusive partner. Other markers that clinicians can use to help identify women who are in abusive relationships are unplanned pregnancies (Espinosa & Osborne, 2002[13]) and miscarriages (Coggins & Bullock, 2003[3]), particularly if both are repeated occurrences.

To provide contraception for women experiencing IPV, clinicians should offer methods that cannot be controlled or destroyed by the partner (Coggins & Bullock, 2003[3]). Condoms, pills, and diaphragms can be found and possibly destroyed by an abusive partner and can lead to a violent episode. These authors suggest Depo-Provera be provided at very low or no cost to these women and be available without an appointment, allowing the woman to get the shot whenever her partner is absent.

2.3 Sexually Transmitted Diseases and HIV

Scope of the Problem. Most evidence suggests that women in abusive relationships are more likely to currently have or have a history of having an STD. Plichta (1996) found that women with a history of abuse were four times more likely to have ever had an STD. Other research shows that women in violent relationships are more likely to currently have an STD (Champion, Shain, Piper, & Perdue, 2001[45]). Using data collected from 744 clients at a prenatal clinic, Johnson and Hellerstadt (2002[18]) found that women who had ever experienced physical or sexual abuse were more than twice as likely to have a history of STDs, as well as currently having an STD. In a study of women at an STD clinic, Bauer et al. (2002[75]) found that 77.4 percent of those experiencing IPV had a history of STDs, whereas only 60.2 percent of those who had not experienced IPV had a history of STDs. Interestingly, the abused women did not report less condom use at last sex. Another study found that women in abusive relationships were more likely to be diagnosed with an STD when coming in with symptoms rather than during a routine exam or STD test (Champion et al., 2001[45]), supporting the pattern of poor self-care noted under the discussion about pregnancy and violence.

Violence in a relationship increases a woman's risk of STDs or HIV by three mechanisms: (1) through intercourse with an infected or high-risk partner; (2) by limiting a woman's ability to negotiate safe sexual behaviors such as condom use, and (3) by establishing a pattern of sexual

risk-taking in the woman (Maman, Campbell, Sweat, & Gielen, 2000[151]). Risk for women is also increased when they are forced into sexual intercourse without arousal, leading to tearing of the vaginal mucosa (Winn, Records, & Rice, 2003[9]).

Evidence for a woman's increased risk of disease because of IPV is strong for each of the three mechanisms. First, women in abusive relationships are often partnered with high-risk men. High risk includes intravenous drug users, HIV-positive men, and men who have sex with men. In a study of more than 400 women surveyed at an STD clinic, the authors found that abused women were more likely than non-abused women to have high-risk sex partners (Bauer et al., 2002[75]). In this same study, the authors found that although a history of having an STD was associated with IPV, this relationship was mediated by high-risk behavior by partners as well as high-risk behavior by the women patients, providing supporting evidence for the third method of transmission. The high-risk behavior most often identified was non-monogamy between partners. This finding is supported by a study of abused women in an HIV-prevention intervention who believed they were at higher risk of STDs and HIV because of their partner's infidelity (Raj et al., 2004[168]). Women experiencing IPV in this study were also less likely to know their partner's HIV serostatus.

Examining the second method of transmission, most evidence supports that women in abusive relationships have limited ability to negotiate for safe sex. The bulk of this evidence examines negotiating condom use and is discussed in the previous section. Other research looking at HIV risk behaviors found that IPV was associated with increased sexual coercion and decreased negotiation of risky sexual practices (e.g., anal sex) and condom use (Kalichman et al., 1998[68]). Kalichman et al.'s study of 125 women living in a low-income housing development also showed that 42 percent of these women had been sexually coerced at one time. Coerced women were more likely to have been given money or drugs in exchange for sex with their most recent partner, believe that their partner had had sex with a man, and believe that their partner is possibly infected. They were less likely to know if their partner had been tested for HIV.

A study by El-Bassel et al. (1998[152]) provides supporting evidence for the second and third methods of transmission. These authors found that women with a history of IPV were significantly more likely to have had sex with a risky partner in the past month, trade sex for drugs or money in past month, have more sexual partners in the past month, ever had an STD and be less likely to have a steady partner in past month. This study also showed that abused women were more likely to refuse to have sex in the past month without a condom. Although this finding is counter to other evidence, it is in line with the Bauer et al. (2002[75]) finding, and both of these studies examined the relationship between current condom use and a history of abuse rather than abuse in the current relationship. Similarly, Raj et al. (2004[168]) found that women reporting previous IPV were more likely than others to report safe-sex negotiation in the recent past. These somewhat counterintuitive findings suggest that women may be applying lessons learned from earlier relationships to their present relationships, an interesting area for further research.

HIV and Violence. Some evidence exists that women who are HIV-positive may be at increased risk for IPV. At present the results are mixed but suggest that some women, depending on their circumstances, will experience higher risk for IPV than HIV-negative women. Gielen et al. (1999[132]) found that HIV-positive women were more likely to experience two or more violent

episodes per month. In another study of HIV-positive women and demographically similar HIV-negative women, the prevalence of violence did not differ between HIV-positive and HIV-negative women, but chronicity was greater among HIV-positive women. Chronicity was measured using the Revised Conflicts Tactic Scale and was defined by the number of violent events in the past month. Experiencing 13 or more violent events in the past month was more likely for HIV-positive women than HIV-negative women (Gielen et al., 2002[60]). These same women were also less likely to be using condoms with their partner, although HIV-positive women were in general more likely to be using condoms.

Despite this evidence, it is difficult to determine if the violence is a direct result of the women's HIV-positive status or related to some other factor. Experiencing IPV and being HIV-positive tend to have the same associated factors such as poverty, partners with substance use problems, maladaptive coping strategies, and mood disorders (Manfrin-Ledet & Porche, 2003[167]). HIV-positive women are more likely to have a partner with a drug or alcohol problem (Gielen et al., 2002[60]) and who has been arrested for a violent offense (Gielen et al. (1999[132]). In a study of pregnant women who were either HIV-positive or at risk for HIV, the rates of IPV did not differ between HIV-positive and HIV-negative women (Koenig et al., 2002[61]). Instead violence was related to the social and economic status of the women. HIV-positive women tend to be socially isolated and economically disadvantaged as a result of their disease. One additional consideration is that for women who are already in abusive relationships or at high risk for abuse, becoming HIV-positive acts as a trigger for violence to begin or escalate (Maman et al., 2000[151]).

Current Issues. The relationship between STDs and IPV is not entirely clear. One possibility (as discussed above) is that HIV-positive women's circumstances – economically, socially, or through the partners she chooses – increase the risk for violence. A second possibility is that the relationship between STDs and IPV is mediated by communication or negotiation between partners. For example, in a study of women partners of male drug users, He, McCoy, Stevens and Stark (1998[67]) found that condom use was not related to a history of physical or sexual violence but that negotiation behaviors (e.g., asking a partner to use a condom) was related to a history of violence. One study that looked at disclosure of STDs by women to their partners found that more women in abusive relationships were uncertain about or would definitely not tell their partner about having an STD (37.3% vs. 22.2%; Champion et al., 2001[45]).

Role of the Clinician. One of the most critical roles for clinicians treating women for STDs or HIV is to recognize the women's circumstances and living situation. Simply urging women to use condoms or abstain from sex with risky partners will likely be viewed with skepticism and concern among women in violent relationships (Kalichman et al., 1998[68]). Encouraging a woman to disclose her HIV status or a history of STD to a violent partner may put her in jeopardy (Maman et al., 2000[151]). The behaviors that clinicians normally encourage to help prevent the spread of disease may not be appropriate or feasible for women not in control of their circumstances. Clinicians should carefully weigh the risk for IPV against the risk for STDs or HIV before suggesting safe-sex behaviors.

One approach has been to offer clinicians alternatives to the traditional STD/HIV prevention advice when women appear to be at risk for violence. For example, Winn et al. (2003[9]) suggests the following:

- Repeated STD screening for women at risk for IPV.
- Always assess women with STDs for IPV.
- Make written materials available to all women about IPV.
- Develop indirect STD prevention approaches for women at risk for violence. Work with them to learn ways of suggesting condom use as a birth control method.

Although clinician training in IPV is important in all areas of reproductive health, training in STD prevention for abused women may be extremely important and popularly given advice may be lacking. For example, in an article published in 2003, Melendez, Hoffman, Exner, Leu and Ehrhardt[2] suggested the following alternative safe-sex strategies be offered to women at risk for violence:

- Refuse or avoid sex with a high-risk partner.
- Choose not to become involved with high-risk partner.
- Leave a sexual relationship with partner who would not engage in safer sex.
- Engage in outercourse.
- Use a barrier method other than condom such as a diaphragm.

These recommendations are quite troubling as all may put women at risk for further violence, yet this paper proposed these as methods to help women in abusive relationships avoid STDs. On the other hand, Manfrin-Ledet and Porche (2003[167]) suggest that the best service that clinicians can offer to women with STDs or HIV at risk for IPV is to help them develop a safety plan that will provide an escape route in the event of violence.

3.0 Family and Intimate Partner Violence Prevention in Clinical Settings

3.1 Protocols and Guidelines for Clinicians

The clinical guidelines shown in Table 3.1 address the physician's or clinician's role in identifying IPV. Our review identified 22 documents that we classified as protocols or guidelines for clinicians. Most of these are published by professional associations, primarily physician associations, for use by their membership. The remaining documents are published by private organizations or government agencies, particularly the Family Violence Prevention Fund. A few of the documents are formal guidelines (#90) but many are position papers developed by a group or committee within the organization providing recommendations in IPV screening and prevention for clinicians. However, for this purpose we identify them as protocols or guidelines because they offer practice recommendations to clinicians. Also included are two documents that are strictly statements of policy. The clinical guidelines were usually developed through literature searches, panels of experts, and surveys of current practice. A few were adapted from extant guidelines from other organizations. Although they are all evidenced-based in some sense, none of the guidelines have been evaluated on a formal basis in practice.

Most guidelines describe how to recognize signs of violence – physical, sexual, verbal, or emotional – and how to address violence appropriately. The guidelines recognize that domestic violence affects women (and men) across the spectrum of income, race, and education. Guidelines exist for many areas of medical practice, including women's health care, emergency rooms, nurses, and even pediatricians. While some suggest specific tools, others give general guidelines for moving though the steps of identification and intervention. Specific recommendations vary but include teaching prevention to all clinicians (and sometimes staff) and screening every patient on every visit. Most emphasize the need to follow a protocol so that when IPV is identified, the medical team can intervene effectively and appropriately. Referral information and resources are typically provided.

Several issues arise in reviewing the guidelines. First, although virtually all providers agree that it is important to be aware of the signs of violence and risk factors for IPV, not all agree on the benefits of universal screening. In fact, mandatory reporting and privacy issues are definite concerns for most physicians as well as for the Family Violence Prevention Fund. Clinicians are reluctant to be put in a situation where they are required to report and reluctant to put their patient in a position of being reported, especially when safety is an issue. Another common concern is that patients do not want to talk to their physician about violence in their lives, although no evidence supports this concern. Several of the guidelines recommend formal training programs in identifying and intervening in situations of IPV.

One issue that arises from an overall review of the guidelines is the fact that many are published by associations of physicians. Only a few are published by non-physician associations and intended for other types of clinicians. Given that many clinicians providing care in Title X-funded clinics are not physicians, the question of whether these protocols and guidelines are known to Title X providers is unanswered.

Table 3.1 Clinical Practice Guidelines on Domestic Violence

Guideline	Purpose	Development	Intended User	Population Served	Content and implementation
American Academy Of Family Physicians Position Paper On Violence	Defines family violence and the role of the family physician in these circumstances.	Literature review. Also recommends use of American Medical Association's guidelines for history-taking around issues of violence and abuse.	Family physicians	Women and families	Primary role: teach parenting and conflict resolution skills that promote respectful and peaceful personal relationships. Be alert for risk factors as well as signs of violence.
American College Of Emergency Physicians (ACEP) Guidelines For The Role Of EMS Personnel In Domestic Violence	Defines the role of the EMS personnel in recognizing and treating victims as well as perpetrators of domestic violence.	Literature review	Emergency medical personnel	Patients in the emergency department and at emergency scenes.	Training in the evaluation and management of victims of domestic violence should be incorporated into the initial and continuing education of EMS personnel. This training should include the recognition of victims and their injuries, an understanding of the patterns of abuse and how this affects care, scene safety, preservation of evidence, and documentation requirements.
ACEP Policy Statement			Emergency medical personnel	Patients in the emergency department and at emergency scenes.	Approved by the ACEP Board of Directors October 1999: The American College of Emergency Physicians encourages emergency personnel to screen patients for domestic violence and appropriately refer those patients who indicate domestic violence may be a problem in their lives.
American Medical Association's Council On Scientific Affairs Data On Violence Between Intimates (I-00)	Assesses the foundation of AMA policy on family violence and gauges the need for possible changes in those policy statements.	Developed using MEDLINE and knowledgeable experts. Examines current literature on family violence, providing an overview of this vast literature. Includes recent statistics and a sketch of current strategies for dealing with violence between male and female intimate partners as well as same-sex partners in intimate relationships.	Physicians	Not specified	Policy H-515.965: AMA will campaign against family violence and remains open to working with all interested parties to address violence. All physicians should be trained in issues of family and intimate partner violence. AMA encourages physicians to routinely inquire about the family violence histories of their patients. AMA urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. AMA strongly supports mandatory reporting of suspected or actual child maltreatment.
Other AMA Council On Scientific Affairs Policies					Violence Against Women (I-91), Policy H-515.9842./ Family Violence: Adolescents as Victims and Perpetrators (A-92), Policy H-515.9813. / Mental Health Consequences of Interpersonal and Family Violence (A-93), Policy H-515.9764. / Alcohol, Drugs, and Family Violence (A-93), Policy H-515.9755. Violence Toward Men: Fact or Fiction? (full text) (I-94), Policy H-515.972
American Medical Association Diagnostic And Treatment Guidelines On Domestic Violence (#90)	Helps physicians recognize and treat the effects of DV and provide referrals for shelter, counseling and advocacy.	Reflects views of scientific experts and literature as of 1992.	Physicians	Women	Identification/screening, assessment, management; examples of screening questions

Table 3.1 Clinical Practice Guidelines on Domestic Violence

Guideline	Purpose	Development	Intended User	Population Served	Content and implementation
American Medical Association Diagnostic And Treatment Guidelines On Elder Abuse And Neglect (#105)	Defines elder abuse and neglect. Reviews physicians' roles and responsibilities.	Reflects views of scientific experts and literature as of 1992.	Physicians	Elders	Physicians' role in detection, management, and prevention of elder abuse and neglect.
American Medical Association Strategies For The Treatment And Prevention Of Sexual Assault (#139)	Defines sexual assault. Reviews physicians' roles and responsibilities.	Reflects views of scientific experts and literature as of October 1995.	Physicians	All	Physicians' role to educate patients on precaution strategies to avert sexual assaults and to address medical, psychological, and social consequences of sexual attacks that have already occurred.
American Medical Association Diagnostic And Treatment Guidelines On Mental Health Effects Of Family Violence (#115)	Defines physician's responsibility to consider, recognize, evaluate, and offer interventions or referrals for mental health problems associated with family violence.	Literature review and review of other AMA policies.	Physicians	Primary care patients	Reviews clinical aspects and clinical presentations associated with victimization. Advised on evaluation and management of cases as well as when to ask and what to ask. Provides referrals resources and discusses legal and reporting issues.
Canadian Task Force On Preventive Healthcare: Prevention And Treatment Of Violence Against Women: Systematic Review and Recommendations	Reviews evidence and makes recommendations regarding universal screening for domestic violence. Also covers counseling and interventions.	Reviewed studies assessing psychometric properties of tools available, but no studies assessed screening or intervention outcomes.	Clinicians	Not-specified	Validated tools exist to detect violence but there is lack of a demonstrated link between screening and the reduction of violence outcomes. This is distinct from the need for clinicians to include questions about exposure to domestic violence as part of their diagnostic assessment of women.
Family Violence Prevention Fund Identifying And Responding To Domestic Violence: Consensus Recommendations For Child And Adolescent Health	Includes guidelines for screening of and intervention with domestic violence victims.	Guidelines developed in partnership with AAP, AAFP, ACOG, NAPNAP, and Child Witness to Violence Project.			

Table 3.1 Clinical Practice Guidelines on Domestic Violence

Guideline	Purpose	Development	Intended User	Population Served	Content and implementation
Family Violence Prevention Fund National Consensus Guidelines On Identifying And Responding To Domestic Violence Victimization In Healthcare Settings (#130)	Presents recommendations on screening for DV, assessment, documentation, intervention, and referrals. Expands guidelines to recommend screening all female and male adolescent and adult patients for domestic violence victimization.		All health care providers	All patients	Recommendations for screening and response. Continuous quality improvement goals to help monitor impact and implementation of abuse identification. Provides specific Screening Guidelines, a Quick Reference, Suggested Screening Questions and Strategies, Validated Abuse Assessment Tools (AAS & Danger Assessment), Indicators of Abuse, and Confidentiality Procedures.
Family Violence Prevention Fund Preventing Domestic Violence: Clinical Guidelines On Routine Screening (#137)	Provides recommendations on how screening should occur within the health care system, including assessment, intervention, documentation, and referral.		All health care providers including mental health providers		Includes general screening policy as well as guide to screening in primary care, emergency care, OB-GYN, family planning, mental health, and in-patient settings. Also suggested screening questions, Abuse Assessment, and documentation forms.
American Academy Of Pediatrics Committee On Child Abuse And Neglect: The Role Of The Pediatrician In Recognizing And Intervening On Behalf Of Abused Women	The AAP and its membership recognize the importance of improving the physician's ability to recognize partner violence as well as child abuse and other forms of family violence.	Literature review and current practices.	Pediatricians in all settings	Mothers of children	The AAP recognizes that family and intimate partner violence (IPV) is harmful to children and recommends that (1) residency training programs and (CME) programs incorporate education on family and IPV, (2) pediatricians should attempt to recognize evidence of family or IPV, (3) pediatricians should intervene in a sensitive and skillful manner that maximizes the safety of women and children victims, and (4) pediatricians should support local and national multidisciplinary efforts to recognize, treat and prevent family and IPV.
American College Of Obstetricians And Gynecologists (#124)	Reviews and recommends domestic violence screening practices.		OB/GYN physicians	OB/GYN patients, including both pregnant and non-pregnant women	ACOG recommends that physicians screen ALL patients for intimate partner violence and ALL patients at EVERY visit for sexual assault. To help physicians with this difficult process, ACOG has developed tools to screen for sexual assault and domestic violence. Tools include list of several questions to ask patient.
CDC; American College Of Obstetricians And Gynecologists Intimate Partner Violence During Pregnancy: A Guide For Clinicians (#127)			Clinicians in prenatal care	Pregnant women	ACOG and CDC slide set on intimate partner violence during pregnancy is designed as a training tool for clinicians to increase understanding of the important role they can play in identifying, preventing, and reducing intimate partner violence. The slide set also emphasizes the critical window of opportunity that prenatal care provides for the screening and referral of pregnant women. The slide set is available for download by visiting CDC's website at www.cdc.gov.

Table 3.1 Clinical Practice Guidelines on Domestic Violence

Guideline	Purpose	Development	Intended User	Population Served	Content and implementation
Massachusetts Medical Society Guide For Physicians And Other Health Care Professionals (#134)	Provides physicians and other health care professionals with basic information about partner violence. Helps them better recognize the varied clinical presentations of partner violence.		Primarily Physicians		Provides background on partner violence. Offers interventions and advice on legal issues. Includes screening recommendations, interviewing techniques, dos and don'ts (question examples), and physical signs of abuse. Uses RADAR.
Nursing Research Consortium On Violence And Abuse Assessment Of Women For Partner Abuse (#27)	Presents strategies for nurses to screen women for past or current intimate partner abuse and guidelines for effective responses to disclosure of abuse.		Nurses	Patients in women's health care settings.	Focus is on interrupting ongoing abuse, ameliorate the effects of abuse, and prevent further abuse. Gives strong rationale for screening every patient regularly and provides advice for making the patient feel confident in their disclosure. Lists indicators of abuse through health history, physical exams, and personal interactions.
Nursingcenter.Com Preventing Abuse During Pregnancy: A Clinical Protocol (#32)	Provides steps to screening pregnant women for abuse.		Clinicians in prenatal care	Pregnant women	Provides step-by-step approach for clinician in detecting abuse including face to face, chart review for indicators, observation of partner's behavior and use of Abuse Assessment.
RADAR: Remember, Ask, Document, Assess And Review (#38)	Addresses shortcomings in current practice of screening and intervention for IPV. Highlights a screening and intervention technique for nurses.		Nurses	Not specified	Provides information on use of RADAR instrument and addresses common barriers to screening for IPV.
San Francisco Medical Society Domestic Violence: A Practical Approach For Clinicians (#116)	Includes screening guidelines.	Adapted primarily from the following sources: San Francisco Domestic Violence Health Care Protocol, developed by the Family Violence Council's Health Care Committee in conjunction with the Family Violence Prevention Fund, 1996; Diagnostic and Treatment Guidelines of Domestic Violence, American Medical Association, 1992.			
Migrant Clinicians Network Addressing Domestic Violence In A Clinical Setting (#104)	Provides health care workers of migrant and immigrant women with a manual for addressing domestic violence in a clinical setting. Gives an understanding of the issues unique to this population and stress importance of screening and documentation.		Migrant health care providers	Migrant and immigrant women	Unique responsibilities of migrant health care providers, myths and facts about domestic violence, warning signs of abuse, effective screening strategies for DV, how to respond when a woman discloses abuse, safety plan guidelines, documentation and reporting. Includes tools for assessment and forms for documentation.

3.2 Tools for Screening and Prevention

We identified a large number of tools intended for clinicians to use in screening for and identifying FIPV (see Table 3.2). Several of the tools were developed for specific studies or interventions and were included in the document for information purposes. But others are well-known instruments such as the Abuse Assessment Screen, HITS (**H**urts, **I**nsults, **T**hreatens and **S**creams), RADAR (**R**outinely screen female patients, **A**sk direct questions, **D**ocument your findings, **A**ssess patient safety, **R**eview patient options and referrals), and WAST (**W**omen **A**buse **S**creening **T**ool) that have been used in many settings. Administration of the tools ranges from open-ended verbal approaches for clinicians such as the Abuse Assessment Screen to short written instruments (3 to 4 questions) intended to be used as part of the overall patient intake screening. However, most of the tools identified are administered verbally rather than in writing. The tools have been developed for use by health care workers, nurses, and physicians in various settings, including prenatal care, emergency situations, Ob/Gyn care and primary care. Several of the well-known tools such as those mentioned above were mentioned several times. Each occurrence of the instrument or tool is recorded in Table 3.2.

The tools are designed to ensure that screening is conducted and that follow-up is complete, including evaluation of a patient's current risk and safety, making a safety plan, and documenting and reporting. Most also recommend screening at every visit, but only a few of the tools have training guidelines for the health care worker. Despite the wide variety of tools, nearly all include recommendations, and there is quite a bit of commonality in these. Recommendations emphasize the need to address the screening setting to facilitate identification of violence in a patient's life. Most advise that the setting and method of asking are as important as the tool. The patient needs to feel comfortable and confident if she is going to share her experiences. The majority of tools emphasize speaking to the patient in a private, non-judgmental, and culturally appropriate manner, using direct questions to ensure clear answers. Providing privacy and confidentiality is also important in encouraging patients to disclose a violent situation.

Not all of the tools included in the database have been evaluated. As mentioned, some were developed for specific purposes and were not validated outside of the immediate use. However, nearly all of these tools were developed based on a literature review, expert opinion, and current practice by clinicians. The tools mentioned in more than one document, such as RADAR, the Abuse Assessment Screen, the Verbal HITS Screen, and the WAST are more likely to have been validated. Typically, these tools were developed using generally accepted instrument development procedures including: (a) careful identification of an initial set of items through literature review as well as input from staff and patients; (b) cognitive testing of the items; (c) pilot testing of the items with the target group; (d) examining the psychometric properties of the items; and (e) validating the items against another instrument or data source.

A useful resource not included in the table is a book called *Assessment of Partner Violence: A Handbook for Researchers and Practitioners* (Rathus & Fiendler, 2004) published by the American Psychological Association. This book reviews many tools for use in a variety of settings and administered using a variety of methods. It also provides a good background in the research and clinical issues in assessing IPV as well as an overview of instrument development.

Table 3.2 Tools for Screening and Prevention

ID	Tool	Purpose	User/Client, Administration method	Development: piloting, evidence-based or evaluation (within the document)	Implementation
5	**Strangulation Documentation Tool**	Guidelines for screening and assessing for strangulation in patients who experience intimate partner violence or sexual assault.	Physicians in emergency departments/ urgent care	Not evaluated	Recommends screening for strangulation in all cases of identified IPV. Describes clinical presentation of a patient who has been strangled and recommends specific aspects of evaluation and documentation to complete.
11	**Abuse Assessment Screen; 4 Questions, Including A Female Figure On Which To Mark Physical Or Threatened Injury**	To help clients overcome common barriers to reporting and screening for abuse within clinical practice.	Physicians, nurses, other health care providers	Not evaluated	In clinic during patient visit.
11	**2nd Abuse Assessment Screen; 4 Questions, Intended To Be Verbally Administered (No Drawing)**	To help clients overcome common barriers to reporting and screening for abuse within clinical practice.	Physicians, nurses, other health care providers	Not evaluated	In clinic during patient visit.
11	**Danger Assessment Screen, Intended To Screen Individuals At Risk Of Homicide**	To help clients overcome common barriers to reporting and screening for abuse within clinical practice.	Physicians, nurses, other health care providers	Not evaluated	In clinic during patient visit.
21	**Abuse Assessment Screen**	To facilitate screening for intimate partner violence.	Physicians and other health care providers in primary care practices	Not evaluated	Should be completed at every visit. Develop a trusting relationship with the client. Take a thorough history, assess mental and physical health, and link physical symptoms with the underlying abuse. Direct questions are the most effective. Training combined with screening can significantly increase detection of IPV.
23	**Abuse Screen Questionnaire (March Of Dimes Protocol)**		Nurses and other health care providers in prenatal clinics in a large urban public health department.	Evaluated	This included in-service education for all staff and weekly visits by a nurse trainer for support, guidance, and new instruction.
27	**Abuse Assessment Screen (Nursing Research Consortium On Violence And Abuse)**	To facilitate screenings on every patient regularly and making the patient feel confident in their disclosure.	Nurses in women's health care settings	Not evaluated	Table I: Indications of abuse through interactions and health history. Table II: Indicators of abuse through physical exam.
28	**Partner Violence Screen: 3 Questions**	To screen for domestic violence in pregnancy.	Obstetricians and other health care providers	Not evaluated	Screening should be done routinely through each trimester.
28	**Abuse Assessment Screen: 5 Questions**	To screen for domestic violence in pregnancy.	Obstetricians and other health care providers	Not evaluated	Screening should be done routinely through each trimester.
29	**HITS (Hurts, Insults, Threatens, And Screams)**	To identify women experiencing domestic violence.	Family physicians	Internal consistency and construct validity evaluated in this paper.	The four items (hurts, insults, threatens, and screams) are asked to a patient to indicate how often her partner does any of these. Patients respond to each item with a 5-point scale.

Table 3.2 Tools for Screening and Prevention

ID	Tool	Purpose	User/Client, Administration method	Development: piloting, evidence-based or evaluation (within the document)	Implementation
32	**Refers To The 3-Question Abuse Assessment Screen, But Does Not Include It**	Screening for abuse during pregnancy.	Nurses	Not evaluated	(1) Assess face to face. (2) Review chart for information that may indicate abuse. (3) Observe partner's behavior. (4) Ensure confidentiality. (5) Ask questions using the Abuse Assessment Screen. (6) Do each visit and record response.
34	**RADAR**	Domestic violence screening and intervention.	Nurses and nurse practitioners in rural family planning clinics.	Evaluated the process of implementing domestic violence screening.	R=Routinely screen female patients, A=Ask direct questions, D=Document your findings, A=Assess patient safety, R=Review patient options and referrals.
37	**Key Questions For Nurse's Routine Assessment**	Screening for IPV.	Nurses	Not evaluated	Screen in private; can occur in any patient encounter and not just once.
37	**The Danger Assessment**	To help women evaluate their own risk of homicide. Self-administered by patient.	Nurses	Not evaluated	If abuse is identified, nurses should assist women in creating a safety plan and ensure follow-up occurs. They should document everything in the medical record and include a lethality assessment.
38	**RADAR**	Domestic violence screening and intervention.	Nurses	Not evaluated	Article reviews how to ask about partner violence and what barriers to be aware of.
43	**Abuse Assessment Screen**	To screening for IPV in pregnancy.	Nurses, nurse midwives, and nurse practitioners in prenatal care sites	Screening rates evaluated in this paper using the aforementioned tool.	Screening should be integrated into routine care and be done by one person consistently if possible.
48	**"Screening For DV In The Emergency Department/Urgent Care, OB/GYN, And Family Planning Setting."**	Careful approach to screening all pregnant trauma patients for intentional trauma.	Care providers in Emergency Department/Urgent Care, OB/GYN, and Family Planning Setting	Not evaluated	During assessment and stabilization of physical injuries, take a confidential social and medical history.
51	**Woman Abuse Screening Tool (WAST)**	Screening for IPV.	Physicians in family practice settings	Assessed validity and reliability of the WAST in the general population within the context of the family practice setting and determined the comfort levels of family physicians administering the WAST. Developed using purposive samples of abused and nonabused women.	
56	**American Medical Association (AMA) Screening Questions**	Screening for IPV.	Physicians and other health care providers	Study used qualitative research methods to determine if there are ways of asking general screening questions in front of children.	Suggested formats of more general questions for IPV screening (Everyone has conflicts; how do you resolve them? What happens in your house when people are angry?).

Table 3.2 Tools for Screening and Prevention

ID	Tool	Purpose	User/Client, Administration method	Development: piloting, evidence-based or evaluation (within the document)	Implementation
60	**Revised Conflict Tactics Scale (CTS2)**	Allows comprehensive view of abuse by measuring the prevalence and chronicity of abuse by partners in an intimate relationship.		Study used the CTS2 to compare abuse experience in HIV+ and HIV- women.	
63	**Orthostatic Challenge Is An Indicator Of The Individual's Response To Stress**	Screening and identifying abused women in prenatal clinics and obstetrical units.	Physicians and other health care providers	Reviews Conflict Tactic Scale (CTS), the Index of Spouse Abuse (ISA), and the Danger Assessment Scale. Discusses biological markers involved in stress response. Although promising, the absence of clinical studies using alpha 2 markers with abused women and its invasive nature are problems.	
76	**Verbal HITS Scale**	Screening for IPV in pregnancy.	Family medicine attending physicians, nurse practitioners, and resident physicians in a family medicine health center in a low-income, ethnically diverse neighborhood	Scale used as part of the intervention in the evaluation of a DV curriculum using baseline and follow-up provider surveys and a qualitative assessment of medical providers' experiences and perceptions with the intervention.	
77	**Violence Screen**	To predict violence against women in the ensuing months.	Survey done with prospective cohort study sampled as part of the Colorado Behavioral Risk Factor Surveillance System (BRFSS)	Violence screen followed up 3-5 months later with the Conflict Tactics Scale (CTS) and parts of the CTS2 Scale. Sensitivity of violence screen 80% for severe physical violence, but marginal to poor for other CTS scales. Specificity was >90% for each abuse outcome measure.	
107	**Domestic Violence Evaluation Tool**	Tool to evaluate the quality of health care and interventions for domestic violence using a health services research paradigm.	Tool is designed to permit a formal assessment of a hospital's performance in implementing a domestic violence program	Tool developed using the Delphi-process.	(1) Set useful benchmarks or objectives for program achievement, (2) assess site's performance repeatedly over time, (3) compare and contrast different programs, and (4) help determine which program features are most important in creating positive long-term outcomes for DV victims.
117	**Power And Control Wheels AND Red Flags To Alert Providers To Ask About Possible Abuse**	Demonstrate how health workers can be part of the problem or the solution through advocacy.	Physicians and other health care providers	Several tools and guidelines from various sources.	
120	**Reference Card For Physicians**	Decision Tree to assess patient's risk of DV and offer appropriate help.	Physicians in all settings	Based on American Medical Association's Diagnostic and Treatment Guidelines on Domestic Violence.	Outlines the protocol for recognizing and treating victims of domestic violence.

Table 3.2 Tools for Screening and Prevention

ID	Tool	Purpose	User/Client, Administration method	Development: piloting, evidence-based or evaluation (within the document)	Implementation
122	**Domestic Violence Health Care Provider Training Evaluation Toolkit**	Assessment of training needs in the area of domestic violence for health care providers.	All health care providers	Evaluated	7 instruments: Respondent Profile I & II, Practice Issues Survey, Presenter Evaluation Form, Presentation Evaluation Form, Domestic Violence Healthcare Provider Survey, Healthcare Provider Survey on Intimate Partner Violence.
123	**Critical/Clinical Pathways For Screening, Identification, And Response.**	Chapter 2 provides a step-by-step description of the identification, assessment, and intervention skills that clinicians need to effectively and sensitively respond to domestic violence in their clinical practices.	All health care providers	Part of Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.	
127	**RADAR: Tool For Screening And Response.**	Slide presentation presents guidelines to clinicians for screening for intimate partner violence during pregnancy.	Pregnancy care/obstetrics	Not evaluated	
127	**Abuse Assessment Screen**	Slide presentation presents guidelines to clinicians for screening for intimate partner violence during pregnancy.	Pregnancy care/obstetrics	Not evaluated	
128	**Red Flags, Predictors And Things To Watch**	To identify signs to watch for before actual abuse and indicators of existing abuse.	Not specified	Not evaluated	
134	**Partner Violence: How To Recognize And Treat Victims Of Abuse**	Screening recommendations: Interviewing techniques, dos and don'ts (question examples), physical signs of abuse, documentation, and risk assessment.	Physicians and other health care providers	Guide developed in conjunction with Massachusetts Medical Society's Campaign Against Domestic Violence and continues to be widely distributed in the medical community and to other states as well.	
134	**RADAR**	Tool to use for recognizing and treating partner violence.	Physicians and other health care providers	Not evaluated	
137	**Suggested Screening Questions**	Provides recommendations on how screening should occur within the health care system.	Health care providers who have been educated about DV and trained how to ask about abuse and intervene as needed.	Part of Preventing Domestic Violence: Clinical Guidelines on Routine Screening by Family Violence Prevention Fund.	Recommends: Routine screening for DV for all female patients over 14 years, culturally competent programs to ensure routine screening. Screenings take place in private settings, using direct, nonjudgmental questions in a face-to-face manner.
137	**Abuse Assessment Screen**	Provide recommendations on how screening should occur within the health care system	Health care providers who have been educated about DV and trained how to ask about abuse and intervene as needed.	Part of Preventing Domestic Violence: Clinical Guidelines on Routine Screening by Family Violence Prevention Fund.	

Table 3.2 Tools for Screening and Prevention

ID	Tool	Purpose	User/Client, Administration method	Development: piloting, evidence-based or evaluation (within the document)	Implementation
137	**Domestic Violence Screening and Documentation Form**	Provide recommendations on how screening should occur within the healthcare system	Health care providers who have been educated about DV and trained how to ask about abuse and intervene as needed.	Part of Preventing Domestic Violence: Clinical Guidelines on Routine Screening by Family Violence Prevention Fund.	
160	**Universal Screening Tool For Intimate Partner Violence**	To be used primarily in hospital settings.	Staff are trained to use the instrument. Training can be done in groups or individually but should be ongoing due to staff turnover.	Committee discussion. Attempt to balance thoroughness with time taken. Does not translate well into Spanish.	Three questions including one about sexual coercion. Staff also record their impressions of the patient. Emphasizes positive messages, making referrals, and creating safety plans.
170	**Proximal Antecedents to Violent Episodes (PAVE)**	Intended to assess stimuli that are likely to elicit IPV.	Self-administered for men to assess their violent triggers.	Validated using batterers. Factor analyzed into 3 types; violence to control, violence out of jealousy, and violence following verbal abuse.	Final scale is 20-item Likert scale to be self-administered by men who may have violent tendencies.
173	**STaT (slapped, things and threaten)**	A simple, sensitive screening tool to assess lifetime IPV.	Health care providers who require a quick but highly sensitive instrument. Administered by clinicians.	Created from Index of Spousal Abuse and Revised Conflicts Tactics Scale. Assessed for sensitivity and specificity.	3-items for lifetime experience of IPV

3.3 Clinical Training Methods and Programs

Descriptions of specific clinical training methods and programs in the area of IPV are limited in the published literature. Our review found only eight documents that described programs we identified as a training method or program. These are included in Table 3.3 below. Four of the eight programs are specific to evaluations that were conducted on the impact of provider education on physician practices in screening for IPV. They generally included providing education for clinicians with pre- and post-tests measuring changes in practice or a follow-up survey of clinicians who attended violence-specific training activities.

Of note is the *Physicians' Reference Card* produced by the American Medical Association that walks a clinician through screening and identification (#120). This is based on the AMA's Diagnostic and Treatment Guidelines on Domestic Violence and provides physicians with a card outlining the protocol and offering recommendations on assessing DV risk in patients as well as how to respond to patient's questions and requests regarding DV. Additionally, the *Domestic Violence Health Care Provider Training Evaluation Toolkit* (#122) is intended to assist organizations in assessing training needs in DV. The toolkit includes instruments for assessing clinician training needs in domestic violence. The Family Violence Prevention Fund's *Making the Connection: Domestic Violence and Public Health* (#179) provides slides and speaker notes to train public health staff. There are 10 sections included, all of which could stand alone as an in-service for clinic staff. The document provides background about a number of health care issues surrounding IPV that are important to Title X-funded clinics including family planning, STDs and HIV, and pregnancy.

As noted above, several evaluations were conducted on the impact of different types of clinician training with varying results. Based on the outcome of increased screening for and identification of IPV, training during residency is very effective for initiating universal screening practices (#7; Borowsky & Ireland, 2002[33]). Looking at how training should be executed, short (one-hour) annual or bi-annual training frequently does not make long-term changes in practices concerning IPV (#42). More intense training programs such as the residency training mentioned above have better results. However, in one study, education improved beliefs about how and when to screen and provided realistic outcome expectations (#62). In general, training that is skills-based and focused on improved self-efficacy appears to be the most effective. Additionally, on-site domestic violence coordinators and frequent reminders are helpful in improving screening practices. The many barriers on the clinicians' part that prevent screening and identification are discussed later in the review.

Also included in Table 3.3 is *A Guide to Training Materials and Programs for Health Care Providers* (#159) from the Centers for Disease Control and Prevention that provides contact information and references about many training programs in sexual assault and IPV. We should note that many resource manuals and tools intended to assist clinicians in screening are often accompanied by training guidelines. Most of these are covered in earlier sections (3.1 and 3.2).

Table 3.3 Clinician Training Methods and Programs

ID	Title	Purpose	Development	Source/Availability	Content/Implementation	Evaluation (if available)
7	**Spouse/Partner Violence Education As A Predictor Of Screening Practices Among Physicians.**	To determine if physicians who received IPV education were more likely to screen for IPV in their patients.	Looked at types and amount of training physicians had received and their screening practices.		Physicians completed self-administered questionnaire with sections on current IPV screening practices, attitudes/opinions, barriers, education on IPV, protocols and policies, physician demographics, patient demographics.	Compared with selected other educational activities, spouse/partner violence education during residency training is effective for initiating universal screening practices
34	**Making Family Planning Clinics An Empowerment Zone For Rural Battered Women.**	Evaluation of the process of implementing domestic violence screening using questionnaires of the staff and activity reports of the on-site medical advocate.	Questionnaires evaluated training and assessed staff's practice of screening and referring patients. Self-administered pre- and post-training and 6 months after training.	Program implemented in 4 rural family planning clinics run by Family Health Council, Inc. Staff used RADAR as model for intervention.	DV training to all patients and staff. Staff attended 5-hour workshop on DV. Also included ongoing training and support for 2 years. Staff used RADAR as model for intervention, which screens and incorporates educational strategies. Staff were to routinely screen all family planning patients in initial and annual visits and prenatal patients at every visit.	Changes in self-reported knowledge and practice suggest the training and tools provided to implement the RADAR model have been effective. There was an increase in reported comfort but some issues are still problematic for the staff and need to be addressed in ongoing training. Those patients reporting abuse and accepting a referral are probably only the tip of the iceberg.
42	**Continuing Education About Physically Abusive Relationships: Does Education Change The Perceptions Of Health Care Practitioners?**	Determine the effectiveness of mandatory continuing education for domestic violence.	Pre- post-test design examining changes in IPV screening practices after the initiation of a mandatory 1-hour biennial continuing education on domestic violence.		A 12-item questionnaire distributed to Perinatal health care professionals attending the National Perinatal Association Conference in Florida in 1993 and 1997.	Health care professionals' perception, awareness, and recognition were not changed by the biennial mandatory continuing education regarding domestic violence.
62	**Health Care Professionals' Skills, Beliefs, And Expectations About Screening For Domestic Violence In A Border Community.**	Analyze the association between the percentage of female patients a clinician screens for domestic abuse and other aspects of the screening process – including outcome expectations, preparedness, and beliefs in order to determine the appropriate domestic violence course content for health care professionals.	Cross-sectional study using a mailed survey to physicians, dentists, and nurse practitioners in El Paso, Texas.		No specific program.	Significant associations existed between education and preparedness, beliefs about how and when to screen, and positive and realistic outcome expectations. This indicates that it may be possible to teach and augment these skills in continuing education for health care professionals. Any educational programs aimed at improving screening rates should emphasize these variables, with particular emphasis being placed on skills-based training to increase feelings of self-efficacy.
117	**Center For Health And Gender Equity Ending Violence Against Women**	Teach health care providers how to ask clients about violence, become better aware of signs that can identify victims of DV or sexual abuse, and help women protect themselves by developing a personal safety plan.			Power and Control Wheels demonstrating how health workers can be part of the problem or the solution through advocacy. Includes tools and guidelines from other sources.	Not evaluated.

Table 3.3 Clinician Training Methods and Programs

ID	Title	Purpose	Development	Source/Availability	Content/Implementation	Evaluation (if available)
120	**Physician's Reference Card : Recognizing And Treating Victims Of Domestic Violence.**	Provide a reference card for physicians outlining the protocol for recognizing and treating victims of domestic violence.	Based on American Medical Association's Diagnostic and Treatment Guidelines on Domestic Violence.		Decision Tree to assess patient's risk of DV and offer appropriate help. Includes recommendations of how to ask and respond to questions, the setting, and response to answer.	Not evaluated.
122	**Domestic Violence Health Care Provider Training Evaluation Toolkit.**	Toolkit for use in assessment of training needs in the area of domestic violence for health care providers. Can use the toolkit to evaluate a range of health care trainings on domestic violence.			Contains 7 different instruments. The Domestic Violence Healthcare Provider Survey measures providers' domestic violence-related knowledge, attitudes, and beliefs, and their perceived ability to act and use information in practice. The Healthcare Provider Survey on IPV measured provider knowledge, attitudes, beliefs, and intended behavior associated with IPV.	Evaluated.
159	**Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers**	Provides an overview of training programs in IPV and sexual assault for all types of health care providers.		Created by CDC/National Center for Injury Prevention and Control	Contains overview of sexual assault and lists the elements of a good curriculum for agencies who want to develop their own curriculum. Existing training materials and programs are reviewed and contact information provided. Organizations that offer trainers are also included.	N/A
179	**Family Violence Prevention Fund Making the Connection: Domestic Violence and Public Health**	To help providers in public health settings connect domestic violence with health issues and provide strategies to respond.	Most information is evidence-based.	Available from Family Violence Prevention Fund.	Slides and speaker notes covering epidemiology and impacts on women's health, family planning, STDs and HIV, pregnancy, and child and adolescent health. Accompanying PowerPoint presentations can be downloaded from www.endabuse.org/health.	N/A

3.4 Evaluated Interventions for Family and Intimate Partner Violence

Battelle identified eight evaluated clinical interventions for FIPV. These are described in Table 3.4. The evaluations focused primarily on screening and identification of intimate partner violence. Although not consistently quantified in any of the intervention studies, it appears that increased screening does result in improved identification of domestic violence among patients. Furthermore, in virtually all of the studies reviewed, interventions and protocols improved screening practices among clinicians to varying degrees. However, the interventions are not entirely successful. Some note that retraining 3 to 6 months later is important as the intervention's effects on clinicians' behavior diminishes over time and one intervention that was very intense resulted in only modest changes in clinicians' behavior (#78).

The interventions that appear to be most effective are ones that address barriers and focus on enabling. Successful interventions use tools, chart prompts, and protocols. More importantly, they involve skills-based training that is continual with organizational support for referrals and treatment, such as a domestic violence coordinator or partnering referral agencies (#76). Of note, one article described an evaluation kit that was developed using the Delphi process to identify measures for evaluating the quality of hospital-based IPV programs to assist researchers, program planners, and administrators in their efforts to implement programs, monitor progress, and improve quality (#73). The RADAR is listed here as an evaluated intervention. It was listed as a tool earlier but the program also includes tips and instructions on clinicians' responsibility to their patients in regard to IPV. The entire RADAR package was evaluated during development and appears to improve knowledge, attitudes, and practices of health care professionals regarding IPV.

Table 3.4 Evaluated Clinical Interventions for FIPV

ID	Title	Purpose	Development	Intended user	Population Served	Content/Implementation	Evaluation Outcomes
20	**Screening For Domestic Violence In The Community Pediatric Setting.**	To gain an understanding of whether screening for domestic violence in the pediatric office setting could be helpful to abused women and their children.			Female guardians who accompanied their children for a pediatric well-child visit with a certain pediatrician.	Pilot study: Women were asked 6 screening questions for domestic violence, including whether she had ever experienced DV and when, whether her partner had hurt her children, and if she was afraid of her current partner. Logistic regression analysis was used to describe differences in responses.	Many women will reveal DV when screened in the pediatric setting. (Up to this point only one previous DV report had been made in 4 years.) The incidence of DV is high regardless of insurance status, suggesting that universal screening be used.
22	**Screening And Intervention For Intimate Partner Abuse: Practices And Attitudes Of Primary Care Physicians.**	To describe screening practices and perceptions regarding IPV of primary care physicians (PCPs).	Cross-sectional survey of a stratified probability sample of physicians. Screening practices in clinical situations addressed, and perceived barriers in a 24-item questionnaire.	Physician	Women		The higher level of screening of patients with injuries likely reflects physicians' awareness that IPV is an important cause of injury. However, the lower level of IPV screening in other clinical situations suggests that PCPs are missing important opportunities to detect IPV.
23	**The Effectiveness Of An Abuse Assessment Protocol In Public Health Prenatal Clinics.**	To evaluate whether incorporation of an assessment protocol into routine procedures of prenatal clinics led to increased referral, identification, and documentation of abuse.	90-minute training was given to the staff in the clinics that used the protocol. The protocol included the Abuse Screen Questionnaire.	Prenatal clinic staff	Pregnant women	Quasi-experimental design with pre- and post-intervention measures and comparison groups to evaluate an abuse protocol. Random samples of 540 charts from the first-visit maternity patient charts covering the 15-month period before the protocol's introduction and then the 15-month period after the protocol were conducted at each of the 3 clinics.	Implementation of an abuse assessment protocol in the prenatal clinics resulted in (1) more pregnant women being assessed and referred for abuse, (2) increased documentation of abuse in maternity medical records. The decline in implementation of the protocol from 3- to 12-month audit suggests the need for reinforcement to maintain implementation.
34	**Making Family Planning Clinics An Empowerment Zone For Rural Battered Women.**	To evaluate the process of implementing domestic violence screening using questionnaires of the staff and activity reports of the on-site medical advocate.	Questionnaires evaluated training and assessed staff's practice of screening and referring patients. Self-administered pre- and post-training and 6 months after training.	Clinical staff in 4 clinics (11 nurse practitioners, 5 registered nurses)	Women and their families in isolated, rural areas attending family planning clinics for routine gyn care, birth control, pregnancy tests, prenatal care, and cancer screening.	DV training to all patients and staff. Staff attended 5-hour workshop on DV. Also included ongoing training and support for 2 years. Staff used RADAR as model for intervention, which screens and incorporates educational strategies. Staff were to routinely screen all family planning patients in initial and annual visits and prenatal patients at every visit.	Changes in self-reported knowledge and practice suggest the training and tools provided to implement the RADAR model have been effective. There was an increase in reported comfort but some issues are still problematic for the staff and need to be addressed in ongoing training.
138	**RADAR: A Domestic Violence Intervention**	To assess, identify, document, and provide referrals for women experiencing IPV.		Clinic Personnel and all health care providers who screen patients for IPV	All	Primarily a tool (listed above) but training is provided in all aspects of a clinician's role in helping patients who are experiencing IPV.	

Table 3.4 Evaluated Clinical Interventions for FIPV

ID	Title	Purpose	Development	Intended user	Population Served	Content/Implementation	Evaluation Outcomes
43	**Screening For Abuse: Barriers And Opportunities**	Examines how pregnant women's psychological and behavioral responses to abuse affect birth outcomes. Screening done by clinicians at each site.			Pregnant women	8 prenatal care sites, including public hospital, large managed care system, community health center, 2 hospital-based prenatal care programs, and 2 hospital-based Perinatal care programs. Program has screening of every pregnant woman for abuse using the Abuse Assessment Screen.	Identified barriers at system level and provider level. Abuse screening by nurses is inconsistent even after retraining and positive reinforcement for screening. Screening should be integrated into routine care and be done by one person consistently if possible.
73	**Measuring The Quality Of Hospital-Based Domestic Violence Programs.**	To obtain expert consensus on performance measures (structure and process) useful for evaluating the quality of hospital-based domestic violence programs.	The Delphi Process of consensus development used in 3 rounds conducted over a 6-month period with each round involving the completion of a written questionnaire.	Researchers, program planners, and administrators	Victims of DV	Round 1 included list of potential measures from prior work. Round 2 included all original and additional suggested measures plus group response to each measure and simple tallies. Respondents then rescored items. Round 3 included these measures grouped into nine major categories. Respondents assigned weights to these and to the individual measures.	Through consensus development, a number of measures have been identified as useful for evaluating the quality of hospital-based DV programs to assist researchers, program planners, and administrators in their efforts to implement programs, monitor progress, and improve quality.
76	**Provider Evaluation Of A Multifaceted System Of Care To Improve Recognition And Management Of Pregnant Women Experiencing Domestic Violence.**	To evaluate a DV curriculum using baseline and follow-up provider surveys and a qualitative assessment of medical providers' experiences and perceptions with the intervention.		All family medicine attending physicians, nurse practitioners, and resident physicians who provided primary care at the center	A family medicine health center in a low-income, ethnically diverse neighborhood	Program included a DV curriculum, a protocol with written chart prompts, a public health campaign, feedback, quality improvement, and a full-time on-site DV coordinator. Questionnaires were distributed before the intervention and 3 months after training, using a validated instrument (MMS DV Survey). 2 focus groups were conducted 3 months post-curriculum. Data were analyzed according to a template approach to text analysis.	System changes such as access to a domestic violence coordinator, chart prompts, and support for providers are accepted and may improve medical responses. The intervention was well received by providers.
78	**Identification And Management Of Domestic Violence - A Randomized Trial.**	To evaluate an intensive intervention directed to primary care practice teams to improve identification of, and assistance for domestic violence victims, using a group-randomized trial.		Clinic personnel (adult care physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, and medical assistants)	Primary care patients	Study took place in 5 primary clinics from a large HMO. Clinics were stratified into 2 groups based on member characteristics and then randomized to intervention (2) or control (3). Intervention included 2 half-day training sessions, extra training for leaders, newsletters, education rounds, system support (posters, questionnaires, etc.), and feedback. Provider knowledge, attitudes, and beliefs were surveyed at baseline (T1) and at 9-10 months (T2) and at 21-23 months (T3). Patient charts were reviewed for rates of asking about DV, case finding, and management at baseline and 9 months.	

3.5 Summary of Family and Intimate Partner Prevention in Clinical Settings

Despite some of the inconsistencies regarding the relationship of IPV to pregnancy, contraception, STDs and HIV, several conclusions can be drawn from the research.

- Screening and other prevention activities by clinicians have increased in recent years. In a study of family physicians in New Hampshire and North Carolina who self-reported on their screening behavior, Glowa, Frasier, Wang, Eaker, and Osterling (2003[154]) found that screening has increased in the last five years, with 15 percent of the male physicians and 25 percent of the female physicians saying they "almost always" screen for IPV. Given that physician (or clinician) inquiry is the best predictor of disclosure of abuse (Walton-Moss & Campbell, 2002[37]), this is encouraging.
- According to physicians' self-report, screening is higher among physicians who have had IPV training (Glowa et al., 2003[154]), suggesting that training for health care workers is an important factor. In a study of health care workers in two rural counties, 41 percent of the health care workers had received training in IPV, but 80 percent of the sample said they have had a situation where they suspected abuse, suggesting that training is not offered or not available to all health care workers who are confronted with IPV. In the same study, 84 percent of the health care workers said they needed more education in FIPV and 90 percent said they would be interested in continuing education credits if available. The lack of available training for these health care workers can be partially explained by working in rural areas. However, even in the Glowa et al. (2003[154]) study, only 30 percent of the physicians had received formal training in IPV.
- While screening is increasing among private physicians and quite common in clinics, the method of screening may be the most important factor. For best results clinicians should:
    - Use direct and indirect questions (Mayer & Liebschutz, 1998[28]). Direct questions may be more likely to detect sexual violence and psychological or emotional abuse that may not fit a woman's own definition of IPV. For example, sexual violence is not always seen by women as abuse, so detecting it sometimes requires a specific question (Campbell et al., 2000[46]). However, indirect questions about physical abuse may avoid panicking a woman or invoking a defensive reaction.
    - Use multiple screening types (written and verbal).Verbal screening is more effective than written screening (Mayer & Liebschutz, 1998[28]) but written screens can alert the clinician to an abusive situation that can be brought up during the exam.
    - Screen at every visit or at least periodically. More than 15 percent of abused women in one study admitted abuse in a subsequent screening after initially denying it (Glander et al., 1998 as cited in Campbell et al., 2000[46]).
    - Screen women in their own language and in a private, confidential setting using non-judgmental language (Saunders, 2000[48]). For example, umbrella words like "abuse" and "violence" may not elicit honest answers from some women because they are value-laden.

  - Clinicians who suspect IPV in a case where a woman will not disclose should ask in a different setting (e.g., the rest room), repeat screening at every visit (Walton-Moss & Campbell, 2002[37]) and if possible, schedule additional visits to provide more opportunities for screening and disclosure (Espinosa & Osborne, 2002[13]).

- Clinicians should look carefully at women who present with conditions associated with FIPV. These include anxiety, depression, substance use, repeated unplanned pregnancies, sleep disorders, post-traumatic stress disorder, headache, and chronic gastrointestinal problems (Walton-Moss & Campbell, 2002[37]). Women with injuries to the face, hands, outer arms, breasts, and abdomen should also be carefully screened.
- Computerized screening techniques can be used in some situations. Rhodes, Lauderdale, He, Howes, and Levinson (2002[164]) developed a screening system for IPV that showed promise. Patients completed their intake screenings on a computer in a private part of the waiting room. The intake screen included a 5-question IPV screener. If a patient's responses indicated an IPV concern, they received information and referrals about IPV immediately via the computer. Their provider also received a notification about the potential IPV for follow-up during the exam. The authors reported that this system detected more incidents of IPV than the traditional written-verbal screening approach, although the system did not perform as well if providers did not conduct the follow-up discussion.

Gaps and Limitations. Two major but related issues stand out in our review of the literature on screening and prevention by clinicians. First, there is very little evidence about the effectiveness of screening and other prevention activities conducted by clinicians (Ramsay, Richardson, Carter, Davidson, & Feder, 2002[86]). Early in 2004, the U.S. Preventive Services Task Force[158] updated their 1996 recommendation regarding screening for FIPV and found insufficient evidence to recommend for or against universal screening of women for IPV. More clinicians are screening and screening practices are improving but real evidence of whether women are more likely to disclose abuse and seek help as a result of screening is lacking. Of the clinical interventions identified in this review, only two gathered data about the rate of reporting as a result of screening. One was a small pilot study (Siegal, Hill, Henderson, Ernst, & Boat, 1999[20]) and the other was the Rhodes et al. (2002[164]) discussed above.

Second, research on screening from the perspective of the patient is lacking. Much of the evidence about what type of screening is effective comes from examination of reporting rates using written or oral screening tools. Articles and guidelines with advice and tips for clinicians regarding screening practices are based primarily on experience and anecdotal evidence. The experience of women with various screening approaches has not been evaluated except in small qualitative studies (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999[80]). For example, it seems likely that some approaches may be ineffective or even offensive, but these have not been identified and thus some clinicians may inadvertently use them. Cultural differences are also likely to impact the effectiveness of screening. Future research in this area could be accomplished with few human subjects' considerations as participants (i.e., patients screened for IPV) would not need to be experiencing abuse in their relationship to respond to questions about their experiences with screening and their perception of the process.

4.0 Issues for Further Consideration

The next section provides a brief overview of issues and topics that are not fully explored in the literature in IPV and reproductive health but represent important considerations for IPV prevention. In keeping with the focus of the project on Title X-funded clinics, the gaps mentioned below are specific to clinics and clinicians.

4.1 Population-Specific Issues

Minors. Screening for IPV among minors requires special consideration for two reasons, and these have not been sufficiently addressed to date. First, providers must find a way to bridge the gap that naturally exists between providers and their minor patients that stems from differences in age, education, experience, and sometimes culture. In a clinical issues article, Glass et al. (2003[71]) identified several concerns specific to a clinicians' need to address adolescent dating violence.

- The use of appropriate language in asking violence-related questions is important. For example, "dating" may not be a meaningful term for adolescents or it may not describe the most frequent kinds of relationships that adolescents are having.
- Violence, jealousy, and control are sometimes perceived among a younger population as a sign of love and commitment. Providers need to consider and address this issue as part of their prevention activities.

More generally, the "youth-friendliness" of clinical experiences, screening and prevention activities, and a clinician's behavior and approach are areas yet to be addressed in IPV prevention among adolescents. Youth-friendliness has been considered in HIV prevention (go to http://www.fhi.org/en/Youth/YouthNet/ProgramsAreas/YouthFriendlyServices/index.htm for further information) and suggests that the clinical experience needs to be respectful, comfortable, and meaningful to young people. In addition, research is required into the types of services required by adolescents in violent relationships (Culross, 1999[162]).

The second issue in regard to screening with adolescents is that they must be advised of local laws regarding reporting of child abuse, particularly sexual abuse. Laws vary by state but typically abuse is considered to include any minor (under 18) having sexual relations with anyone over 18 and/or more than 5 years older than themselves. These cases must be reported to local law enforcement or child protective services depending on the jurisdiction. Physical abuse of a minor by a partner is also typically reportable. This presents a problem for clinicians in terms of IPV screening and prevention activities with minors. How this impacts the frequency of screening by the clinician or reporting by the minor is unexplored.

Race/Ethnicity. One of the most often researched areas is the effect of race and ethnicity on IPV and reproductive health, but results are difficult to interpret. The difficulty primarily stems from the high correlations of race/ethnicity with other variables such as education and income that are

important risk factors for IPV. Early research suggested that African-American women were the most likely to experience violence in a relationship and Hispanic women were the least likely to experience violence, with Anglo-American women in the middle of the two groups. More recent research has not always shown this pattern. Although we did not specifically examine the influence of race/ethnicity in this review, we found a number of studies with inconsistent results. Several examples are below.

- In a study of female partners of drug users, He et al. (1998[67]) found that white, non-Hispanic women in reported the highest rates of physical and sexual violence, followed by Native Americans and Mexican Hispanics, with Puerto Rican Hispanics showing the lowest rates of physical and sexual violence. A study of pregnant women that examined rates of abuse before and during pregnancy among three Hispanic groups (Central American, Puerto Rican, Cuban American), African-Americans, and Anglo-Americans found that results varied depending on the assessment instrument used and whether demographic factors were controlled for in the analysis (Torres et al., 2000[47]). These authors found that when demographic factors were controlled for, there was no difference in rates of IPV before or during pregnancy among women of different races. However, they found that even after controlling for demographic factors, the woman's partner's race was significantly related to IPV during pregnancy. Cuban American and Central American partners were less likely to abuse their pregnant partners than men from other groups.
- Other studies report that Native Americans have the highest rates of IPV. For example, in a small study of Native American women, Bohn (2002[39]) found that 87 percent of the women reported physical or sexual abuse at some point in their life.

It is difficult to even summarize the results regarding race/ethnicity and IPV. Some authors (e.g., Mayer & Liebschutz, 1998[28]) have concluded that race is not an independent factor. In any case, it is not a simple relationship and may depend on a number of factors. Measurement issues, specific reproductive health factors (pregnancy, contraception, disease), and the socio-demographic characteristics of the samples are all likely to be important pieces of an ever-evolving puzzle. There also remains the possibility that some type of interaction between race/ethnicity and income or education exists, requiring analysis of a large, population-based sample to discover.

Men. Finally, it is worth noting that none of the articles or documents included in this review substantially considered men either as partners or concerned others (e.g., fathers, brothers, or friends). Of the research and evaluation articles reviewed, none of them included a male viewpoint or direct reports of male characteristics or behavior. Our focus in this review was on reproductive health and clinical issues as they related to IPV, so it is understandable that most of the articles are about women or based on reports made by women. But given that men are the primary perpetrators of violence against women, that they occasionally experience IPV themselves, and that they sometimes have women whom they care about at risk for abuse, men seem to be a missing factor in the area.

4.2 Ethical Issues and Legal Issues

Harm Resulting from Screening and Prevention. It is possible that direct harm or violence could come to a patient as a result of a clinician's screening or prevention activities by triggering violent behavior from an abusive partner. Indirect harm could come about by an abusive partner prohibiting the patient from further medical care after an initial screening for IPV or provision of related written materials to the patient. In our review, we found no studies suggesting that screening and prevention activities are harmful or dangerous for patients, although there seems to be a paucity of research specifically directed at this problem. Ramsay et al. (2002[86]) similarly concluded that while there was no evidence of harm, there was also very little research in the area.

Another area where harm could result is from the consequences of mandatory reporting laws. As in the case of minors, state laws vary about what is reportable in regard to violence, although when both partners are adults reporting laws are typically less stringent. Nevertheless, a number of states (e.g., California and Colorado) have laws requiring health care providers to report suspected cases of DV to law enforcement. Supporters of mandatory reporting laws believe that they will enhance patient safety, improve the health care system's response, and improve surveillance data collection (Culross, 1999[162]). But detractors such as the Family Violence Prevention Fund are concerned that mandatory reporting will deter women from getting help and that the perceived breach of patient-provider confidentiality will weaken this important relationship. Culross (1999[162]) conducted a survey of physicians and found that most hold these negative beliefs about mandatory reporting. In addition, some detractors of mandatory reporting argue that reporting IPV could put a patient in danger of an attack from their partner as a result. Thus the laws designed to protect women may be putting them in greater jeopardy.

Encouraging Healthy Reproductive Health Behaviors. A second ethical issue surrounding IPV and reproductive health is how clinicians can encourage and support reproductive health behaviors such as condom and contraceptive use, disclosure of HIV/AIDS and STDs, and avoidance of risky sexual behaviors such as unprotected sex, non-monogamy and risky partners without jeopardizing a woman's safety within an abusive relationship. Advice for clinicians in this area is limited and, as noted earlier, it may not be particularly sound. Campbell et al. (2000[46]) in a nursing research-to-practice review has recommended against encouraging safe-sex behaviors among these women as the consequences of not practicing safe sex may present less danger than IPV.

4.3 Barriers to Screening and Prevention

Clinicians perceive a number of barriers related to screening and prevention that inhibit their willingness to screen women for IPV (Garimella, Plichta, Houseman, & Garzon, 2000[65]; Ramsay et al., 2002[86]; Walton-Moss & Campbell, 2002[37]). These include:

- Lack of education about IPV and how to handle it
- Lack of experience in handling IPV with patients
- Fear of offending patients by asking screening questions or providing prevention literature
- Fear of endangering patients by sparking violence from a partner as a result of screening questions or IPV literature

- Perceived lack of effective interventions for patients identified as experiencing IPV
- Limited time to spend with patients
- Belief that IPV screening and prevention are very time consuming
- Fear of legal involvement as a result of reporting IPV or providing referrals for patients

In addition, clinicians, particularly doctors, often believe that they can "fix" any problem (Culross, 1999[162]), very much in keeping with a medical model. However, clinicians may find helping a patient in an abusive relationship frustrating because there are no quick solutions – their patient may not even be ready or able to leave the relationship. This frustration can discourage them from broaching the topic. Training in IPV for clinicians could help to address these issues.

5.0 Summary and Conclusions

Battelle's review of FIPV published papers and web-based documents written from 1999 to the present uncovered a number of findings that have important implications for Title X-funded family planning clinics and will contribute much to Battelle's final report of promising practices. Some of the important findings are summarized below.

The reproductive health of women experiencing IPV is seriously impacted by violence and abuse. Research on IPV and pregnancy, contraception, and STDs/HIV all demonstrate this impact.

- While pregnancy does not appear to introduce IPV into a relationship, it is a cause of stress that can increase the level of violence in an already abusive relationship. Pregnancy also is negatively impacted by IPV through poor self-care such as late entry into prenatal care and non-optimal weight gain during pregnancy. In addition, pregnant women experiencing IPV are also more likely to use drugs, alcohol, and tobacco, and to experience anxiety and depression. The infant is negatively impacted through low birth weight.
- Inconsistent use of contraceptives including condoms is common in abusive relationships and frequently leads to unplanned pregnancies. Abusive partners want to control contraception and may take condoms, pills, and diaphragms away from their partners. Abusive partners believe a woman's access to contraception will lead to infidelity on her part. Condoms, in particular, seem to be value-laden, indicating not only the possibility of infidelity on the woman's part but distrust of her partner and a suggestion of disease.
- Women experiencing IPV are more likely to have a history of STDs or to currently have an STD. They are also at greater risk for contracting an STD or HIV through high-risk partners, an inability to negotiate safe sex, and their own high-risk behavior. HIV, like pregnancy, acts as a stressor that increases the level of violence in an already abusive relationship.

Clinicians have an enormous role in the identification of IPV and in helping their patients cope with the situation. They can begin by being alert to signs of IPV such as poor self-care, suspicious patterns of injuries, repeated unplanned pregnancies, repeated miscarriages, inconsistent use or non-use of contraceptives in women who do not want to get pregnant, and risky sexual behaviors such as having risky partners, a high number of partners, or unprotected intercourse with casual partners. They can also help by:

- Using the trusting relationship they have with their patients (particularly in prenatal care) to identify IPV by screening at every visit. Careful and sensitive screening is the best predictor of IPV disclosure. Successful screening techniques include:
    - Using direct questions to detect verbal and sexual abuse.

  - Using non-judgmental language in asking about IPV and avoiding value-laden words or conclusions.
  - Screening in a private setting in woman's first language.
- Providing birth control methods that cannot be taken or destroyed by partners in a flexible and low-cost manner.
- Recognizing a woman's situation and not providing advice that may endanger her. Sometimes the best thing a clinician can do is provide referrals and help the patient make a safety plan.

One of the most pressing provider-specific issues is the necessity and availability of training in IPV prevention for providers. Training increases screening and detection; and although the rate of IPV training among providers is increasing, it is not particularly high. It also appears that more providers are interested in training than there is available to them.

Finally, the evidence base in regard to screening and prevention by clinicians needs to be strengthened for universal, appropriate, and effective screening by clinicians to become a reality. In 1996, the U.S. Preventive Services Task Force reviewed the available evidence and could not make a recommendation encouraging universal screening of patients for FIPV because of a lack of evidence. In 2004, the Task Force again reviewed the available evidence and again could not make a recommendation encouraging universal screening because of a lack of evidence. In this review, we have identified a number of areas where the evidence base for FIPV screening and prevention by clinicians could be strengthened. Doing so will ensure that recommendations and guidelines from professional organizations and government agencies will result in effective screening methods and the prevention of FIPV, and that the Task Force's next review will result in a decision based on existing evidence.

Appendix A

Family and Intimate Partner Violence Prevention Websites

Appendix A

FAMILY AND INTIMATE PARTNER VIOLENCE PREVENTION WEBSITES

Host	Address
Administration for Children and Families	www.acf.dhhs.gov/programs/ocs
Adult Protective Services, Virginia Department of Social Services	www.dss.state.va.us/family/adultprotect.html
Alabama Coalition Against Domestic Violence	www.acadv.org
Alan Guttmacher Institute	www.agi.org
Alaska Family Violence Prevention Project	health.hhs.state.ak.us/dph/msfh/akfvpp
Alaska Network on Domestic Violence and Sexual Assault	http://www.andvsa.org
American Academy of Pediatrics	www.aap.org
American Association of Health Plans	www.aahp.org
American Association of People with Disabilities	www.aapd.com
American Bar Association – Commission on Domestic Violence	www.abanet.org
American College of Emergency Physicians	www.acep.org
American College of Nurse Midwives	www.acnm.org
American College of Obstetricians and Gynecologists American College of Obstetricians and Gynecologists (ACOG) Resources on Violence Against Women	www.acog.org http://acog.org/from_home/departments/category.cfm?recno=17&bulletin=1476
American Medical Association AMA Physicians Guidelines To Intimate Partner Violence	www.ama-assn.org http://www.ama-assn.org/ama/pub/category/4605.html
American Medical Women's Association	www.amwa-doc.org
American Nurses Association	www.ana.org
American Psychological Association	www.apa.org
Asian and Pacific Islander American Health Forum	www.apiahr.org
Asian Health Services	http://www.ahschc.org
Asian Women's Shelter	www.emf.net/~cheetham/gasner-1.html
Association of American Indian Physicians	www.aaip.com
Association of Trauma Stress Specialists	www.atss-hq.com/a/indix.htm
Battered Women and Their Children	www.cwolf.uaa.alaska.edu/~afrhm1/
Battered Women's Justice Project	www.bwjp@aol.com
Beliefs and Screening Practices of Virginia Physicians Regarding Spouse/Partner Violence	http://www.vahealth.org/civp/domesticviolence/survey.pdf
Bureau of Primary Health Care	www.bphc.hrsa.gov
California Alliance Against Domestic Violence	http://www.caadv.org
California Medical Training Center	www.ucdmc.ucdavis.edu/medtrng/
CDC – National Center for Injury Prevention and Control, Div. of Violence Prevention CDC/ACOG Online Slide Show on Intimate Partner Violence During Pregnancy: A Guide for Clinicians	www.cdc.gov http://www.cdc.gov/nccdphp/drh/wh_violence.htm
Center for Prevention of Sexual and Domestic Violence	cpsdv.cpsdv.org
Connecticut Primary Care Association	www.ctpca.org
DC Coalition Against Domestic Violence	http://www.dccadv.org
El Centro del Barrio	http://www.tachc.org/tm_cdb.htm
Family Violence and Sexual Assault Institute	www.fvsai.org
Family Violence Prevention Fund	www.fvpf.org
Florida Coalition Against Domestic Violence	http://www.fcadv.org

Host	Address
FVPF Natl. Health Resource Center on Domestic Violence Preventing Domestic Violence: Clinical Guidelines on Routine Screening Practical Counseling Tools & Patient Materials	www.endabuse.org/health http://endabuse.org/programs/healthcare/files/screpol.pdf http://endabuse.org/programs/display.php3?DocID=40
Gay and Lesbian Medical Association	www.glma.org
Health Resources and Services Administration: Domestic Violence Training Initiative	www.hrsa.gov/omh http://www.hrsa.gov/omh/domesticviolence/index.cfm
Institute on Domestic Violence in the African American Community	www.dvinstitute.org
International Association of Forensic Nurses	www.forensicnurse.org
Jacobs Institute of Women's Health	www.jiwh.org
Jane Doe, Inc.	http://www.janedoe.org/index.htm
Johns Hopkins University School of Nursing	www.son.jhmi.edu
Kansas Coalition Against Sexual and Domestic Violence	http://www.kcsdv.org
March of Dimes – "Abuse During Pregnancy: A protocol for prevention and intervention, 2nd edition"	www.marchofdimes.com
Massachusetts League of Community Health Centers	http://www.massleague.org
Massachusetts Medical Society	www.massmed.org
Men Stopping Violence	www.menstopping.violence.org
Michigan Coalition Against Domestic & Sexual Violence	http://www.mcadsv.org
Migrant Clinicians Network	www.migrantclinician.org
Migrant Clinicians Network	www.migrantclinician.org
Monroe Health Center	http://www.monroehealthcenter.com
Montana Coalition Against Domestic & Sexual Violence	http://www.mcadsv.com
National Alliance for Hispanic Health	www.hispanichealth.org
National Asian Women's Health Organization	www.nawho.com
National Black Women's Health Project	www.sisternet.org
National Center for Farm Worker Health	www.ncfh.org
National Coalition Against Domestic Violence	www.ncadv.org
National Coalition for the Homeless	nch.ari.net
National Coalition of Anti-Violence Programs	www.lambda.org
National Council on Child Abuse and Family Violence (NCCAFV)	nccafv.org
National Hispanic Medical Association	home.earthlink.net/~nmha
National Institute of Justice	www.ojp.usdoj.gov/nij
National Latino Alliance for the Elimination of Domestic Violence	www.dvalianza.com
National Medical Association	www.nmanet.org
National Network to End Domestic Violence	www.nnedv.org
National Organization on Disability	www.nod.org
National Resource Center on Domestic Violence	www.pcadv.org
National Sexual Violence Resource Center	www.nsvor.org
National Youth Violence Prevention Resource Center	http://www.safeyouth.org/topics/intimate.htm
Native American Women's Health Education Resource Center	www.nativeshop.org
No Woman Deserves to Hurt, Domestic Violence Education For Women's Health Care Providers, Manual and Videos	http://www.shopacnm.com/domviolvidma.html
Nursing Network to End Violence Against Women International	www.nnvawi.org
Ohio Domestic Violence Network	http://www.ohiodvnetwork.org
Oklahoma Coalition Against Domestic Violence and Sexual Assault	http://www.ocadvsa.org

Host	Address
Oregon Coalition Against Domestic and Sexual Violence	http://www.ocadsv.com
Pennsylvania Coalition Against Domestic Violence/National Resource Center on Domestic Violence	http://www.pcadv.org
Physicians for a Violence Free Society	www.pvs.org www.cdc.gov/nccdphp/drh/violence/slides/acogcdc_ipv.pps
Physicians for Social Responsibility	hometown.aol.com/psrphila
Physician's Reference Card (New York Department of Health	http://www.serve.com/zone/profinfo/referenc.html
RADAR: A Domestic Violence Intervention	http://www.opdv.state.ny.us/health_humsvc/health/radar.html
Sacred Circle National Resource Center to End Violence Against Native Women	www.scircle@sacred-circle.com
San Francisco Medical Society	http://www.sfms.org/domviol.htm
Seattle Indian Health Bureau	http://www.sihb.org
Society of Academic Emergency Medicine	www.saem.org
Sexual Assault Coalition Resources Sharing Project	www.resourcesharingproject.org
Statewide California Coalition for Battered Women	http://www.sccbw.org
Tennessee Coalition Against Domestic and Sexual Violence	http://www.tcadsv.citysearch.com
Texas Council on Family Violence	www.tcfv.org
The Family Health Center	www.marshfieldclinic.org
US Dept of Justice – Domestic Violence	www.usdoj.gov/domesticviolence.htm
US Public Health Service – Office on Women's Health	www.4women.gov/owh
Violence Against Women Office	www.ojp.usdoj.gov/vawo/
Violence Against Women Resources for Medical Professionals	http://www.mcadsv.org/mrcdsv/resource/Bibliographies/Medical%20Resources.pdf
Virginia Domestic Violence Programs	www.vadv.org/virgdvprograms.html
Virginians Against Domestic Violence	http://www.vadv.org
Washington State Coalition Against Domestic Violence	http://www.wscadv.org
Washington State Department of Health	www.doh.wa.gov
West Virginia Coalition Against Domestic Violence	www.wvcadv.org
William F. Ryan Community Health Center	http://www.ryancenter.org
Women Matter	www.womenmatter.com/indes.shtml

Appendix B
Annotated List of Family and Intimate Partner Violence Documents

Appendix B

Annotated List of Family and Intimate Partner Violence Documents

ID: 1

Document Title The health consequences of child sexual abuse and partner abuse for women attending general practice

Author Hegarty, Kelsey

Journal/Affiliation Australian Family Physician

Publication Date Sep 2003

Comments Brief editorial review of articles addressing health consequences of sexual and partner abuse.

ID: 2

Document Title Intimate partner violence and safer sex negotiation: Effects of a gender-specific intervention

Author Melendez, Rita; Hoffman, Susie; Exner, Theresa; Leu, Cheng-Shiun; Ehrhardt Anke

Journal/Affiliation Archives of Sexual Behavior

Publication Date Dec 2003

Comments A randomized trial examining the effects of HIV/STD prevention interventions in women reporting IPV and its effect on negotiation skills and safer sex. Higher dosage decreased unprotected sex occasions and neither increased IPV.

ID: 3
Document Title The wavering line in the sand: The effects of domestic violence and sexual coercion

Author	Coggins, Margi; Bullock, Linda
Journal/Affiliation	Issues in Mental Health Nursing
Publication Date	Sep-Nov 2003
Comments	Qualitative study (focus groups) of abused women that revealed themes regarding pregnancy, tactics of abuse, inability to access birth control, denial and mistrust.

ID: 4
Document Title Describing abuse of pregnant women and their healthcare workers in rural Appalachia

Author	Denham, Sharon
Journal/Affiliation	The American Journal of Maternal Child Nursing
Publication Date	Jul/Aug 2003
Comments	Descriptive study of abuse in pregnant women and healthcare workers in Appalachia. Also briefly addressed assessment education and policies.

ID: 5
Document Title Strangulation injuries

Author	Funk, Maureen; Schuppel, Julie
Journal/Affiliation	Wisconsin Medical Journal - Official Publication of the State Medical Society of Wisconsin
Publication Date	2003
Comments	Presents guidelines for screening and assessing for strangulation in patients who experience intimate partner violence or sexual assault. Includes strangulation screening tool.

ID: 6

Document Title The relationship between attitudes toward pregnancy and contraception use among drug users

Author Gutierres, Sara; Barr, Alicia

Journal/Affiliation Journal of Substance Abuse Treatment

Publication Date 2003

Comments Study looks at gender and ethnic differences in drug user's attitudes toward pregnancy, abortion, and contraception and relation to history of sexual abuse.

ID: 7

Document Title Spouse/partner violence education as a predictor of screening practices among physicians

Author Sitterding, Heather; Adera, Tilahun; Shields-Fobbs, Erima

Journal/Affiliation Journal of Continuing Education in the Health Professions

Publication Date Winter 2003

Comments Study examining types of education received by ~500 physicians in Virginia and their practices regarding screening for IPV. Suggests that partner violence education in residency is effective in promoting universal screening.

ID: 8

Document Title Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states

Author Saltzman, Linda; Johnson, Christopher; Gilbert, Brenda; Goodwin, Mary M

Journal/Affiliation Maternal and Child Health Journal

Publication Date Mar 2003

Comments Describes and compares the levels and patterns of physical abuse before and during pregnancy. Used population-based estimates from the Pregnancy Risk Assessment Monitoring System. Prevalence of physical abuse during pregnancy across the 16 states was consistently lower than that before pregnancy.

ID: 9

Document Title The relationship between abuse, sexually transmitted diseases, & group B streptococcus in childbearing women

Author	Winn, Nicole; Records, Kathie; Rice, Michael
Journal/Affiliation	The American Journal of Maternal Child Nursing
Publication Date	Mar/Apr 2003
Comments	Examined relationship between abuse, STD's and Group B Streptococcus among Hispanic women. Showed that abused women were at increased risk for STDs and GBS.

ID: 10

Document Title The interrelationship between violence, HIV/AIDS, and drug use in incarcerated women

Author	Harris, Ruth; Sharps, Phyllis; Allen, Karen; Anderson, Elizabeth; Soeken, Karen; Rohatas, Acharaporn
Journal/Affiliation	Journal of the Association of Nurses in AIDS Care
Publication Date	Jan/Feb 2003
Comments	Study examined how violence co-occurs with drug use and high-risk sexual behaviors 170 women reporting violence. Significant bivariate relationships were found between IPV and HIV/AIDs risk behaviors.

ID: 11

Document Title Assessment for intimate partner violence in clinical practice

Author	American College of Nurse-Midwives
Journal/Affiliation	Journal of Midwifery & Women's Health
Publication Date	Sep/Oct 2002
Comments	Provides list of resources and tools for domestic violence and abuse screening in clinical practice. Provides 3 screeners for IPV; also includes multi-city list of domestic violence resources

ID: 12
Document Title Identifying intimate partner violence at entry to prenatal care: Clustering routine clinical information

Author Anderson, Barbara; Marshak, Helen; Hebbeler, Donna
Journal/Affiliation Journal of Midwifery & Women's Health
Publication Date Sep/Oct 2002
Comments Study identifies correlates of routine entry information with responses on validated IPV screening tool in order to identify specific routine data which would alert clinicians to the possibility of IPV. Abused women were more likely to be young, single and without family or partner support.

ID: 13
Document Title Domestic violence during pregnancy: Implications for practice

Author Espinosa, Lisa; Osborne, Kathryn
Journal/Affiliation Journal of Midwifery & Women's Health
Publication Date Sep/Oct 2002
Comments Literature/research review of associations between domestic violence during pregnancy and demographic and lifestyle variables. Also reviews the literature regarding assessment and intervention strategies.

ID: 14
Document Title Prevalence and complications of physical violence during pregnancy

Author Rachana, Chibber; Suraiya, Khwaja; Hisham, Al-Sibai; Abdulaziz, Al-Mulhim; Hai, Abdul
Journal/Affiliation European Journal of Obstetrics, Gynecology, and Reproductive Biology
Publication Date Jun 10 2002
Comments Association between self-reported physical violence in pregnancy and pregnancy complications and/or negative birth outcomes. Abused women more likely to experince antenatal complications.

ID: 15

Document Title Influence of abuse on condom negotiation among Mexican-American women involved in abusive relationships

Author Davila, Yolanda

Journal/Affiliation Journal of the Association of Nurses in AIDS Care

Publication Date Nov/Dec 2002

Comments Qualitative study examining influence of abuse on condom negotiation behaviors among battered Mexican and Mexican-American women.

ID: 16

Document Title The relationship among demographics, reproductive characteristics, and intimate partner violence

Author Rickert, Vaughn; Wiemann, Constance; Harrykissoon, Samantha; Berenson, Abbey; Kolb, Elizabeth

Journal/Affiliation American Journal of Obstetrics and Gynecology

Publication Date Oct 2002

Comments Examines associations between demographics and reproductive characteristics and IPV. Different patterns of risk emerge between physical and verbal assault in young women at publicly funded family planning clinic.

ID: 17

Document Title Abuse history and nonoptimal prenatal weight gain

Author Johnson, Pamela; Hellerstedt, Wendy; Pirie, Phyllis.

Journal/Affiliation Public Health Reports

Publication Date Mar/Apr 2002

Comments Study examined differences among women who do and do not report current IPV in prenatal weight changes. Showed association between abuse and excessive weight gain.

ID: 18

Document Title Current or past physical or sexual abuse as a risk marker for sexually transmitted disease in pregnant women

Author Johnson, Pamela; Hellerstedt, Wendy

Journal/Affiliation Perspectives on sexual and reproductive health

Publication Date Mar/Apr 2002

Comments Examined association between IPV and STD. Abused women have higher risk of history of STD and current infection.

ID: 19

Document Title The effects of domestic violence during pregnancy on maternal and infant health

Author Huth-Bocks, Alissa; Levendosky, Alytia; Bogat, G. Anne

Journal/Affiliation Violence and Victims

Publication Date Apr 2002

Comments Study examined consequences of domestic violence during pregnancy. Found some associations between DV and pregnancy complications although some were eliminated when controlling for income.

ID: 20

Document Title Screening for domestic violence in the community pediatric setting

Author Siegel, R. M.; Hill, T. D.; Henderson, V. A.; Ernst, H. M; Boat, B. W.

Journal/Affiliation Pediatrics

Publication Date Oct 1999

Comments Pilot study to gain understanding of whether screening in a pediatric office setting would be beneficial in identifying domestic violence. Many women revealed DV when screened in the pediatric setting.

ID: 21
Document Title Women battering in primary care practice

Author Naumann, P.; Langford, D.; Torres, S.; Campbell, J.; Glass, N.
Journal/Affiliation Family Practice
Publication Date Aug 1999
Comments Article is primarily a literature review describing the prevalence of IPV and reviewing the known physical, mental health, and pregnancy consequences of abuse, and discussing the implications of IPV on primary care practices. An assessment tool is provided.

ID: 22
Document Title Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians

Author Rodriguez, M. A.; Bauer, H. M.; McLoughlin, E.; Grumbach, K.
Journal/Affiliation Journal of the American Medical Association
Publication Date Aug 1999
Comments Evaluates screening practices and perceptions of IPV among primary care physicians. Found most common barriers to screening were patient related including patient's fear of retaliation by partner and lack of disclosure of battering during history taking. Physicians identified fear of police involvement, lack of follow-up on referrals, and cultural differences. Less than half identified lack of training, time, information or belief that physicians can't make a difference.

ID: 23
Document Title The effectiveness of an abuse assessment protocol in public health prenatal clinics

Author Wiist, W. H.; McFarlane, J.
Journal/Affiliation American Journal of Public Health
Publication Date Aug 1999
Comments Evaluates whether incorporation of an abuse assessment protocol into routine procedures of prenatal clinics led to increased referral for and assessment, identification, and documentation of abuse. Resulted in (1) more pregnant women being assessed and referred for abuse, (2) increased documentation of abuse in maternity medical records. Decline in implementation of the protocol from 3- to 12-month audit suggests the need for reinforcement to maintain implementation.

ID: 24

Document Title Clinical factors affecting physicians' management decisions in cases of female partner abuse

Author Ferris, L. E.; Norton, P. ; Dunn, E. V ; Gort, E. H.

Journal/Affiliation Family Medicine

Publication Date Jun 1999

Comments Addresses physicians' response to abuse in regard to treatment (rather than screening.)

ID: 25

Document Title Severity of abuse before and during pregnancy for African American, Hispanic, and Anglo women

Author McFarlane, J.; Parker, B.; Soeken, K.; Silva, C.; Reed, S.

Journal/Affiliation Journal of Nurse Midwifery

Publication Date Mar/Apr 1999

Comments Study examined how the severity of abuse changed before, during, and after pregnancy for a multi-ethnic group of women. Timing and severity of abuse did not vary by ethnicity. Majority of women abused during pregnancy were abused prior to.

ID: 26

Document Title Interpersonal violence and the pregnant homeless woman

Author Robrecht, L. C.; Anderson, D. G.

Journal/Affiliation Journal of Obstetric, Gynecologic, and Neonatal Nursing

Publication Date Nov/Dec 1998

Comments Review of violence and abuse among homeless, pregnant women with recommendations for assessment and intervention.

ID: 27
Document Title Assessment of women for partner abuse

Author	Fishwick, N. J.
Journal/Affiliation	Journal of Obstetric, Gynecologic, and Neonatal Nursing
Publication Date	Nov/Dec 1998
Comments	Presents strategies for nurses to screen women for past or current intimate partner abuse and provides guidelines for effective responses to disclosure of abuse.

ID: 28
Document Title Domestic violence in the pregnant patient: Obstetric and behavioral interventions

Author	Mayer, L; Liebschutz, J.
Journal/Affiliation	Obstetrical & Gynecological Survey
Publication Date	Oct 1998
Comments	Review of the issue of domestic violence in pregnant patients with small section on screening methodology and tool for IPV and larger section on treatment. Uses "Stages of Change" model.

ID: 29
Document Title HITS: a short domestic violence screening tool for use in a family practice setting

Author	Sherin, K. M.; Sinacore, J. M.; Li, X. Q.; Zitter, R. E. ; Shakil, A.
Journal/Affiliation	Family Medicine
Publication Date	Jul/Aug 1998
Comments	Evaluates screening tool (HITS) and its internal consistency and concurrent validity in ability to differentiate family practice patients from abuse victims.

ID: 30
Document Title Delayed entry into prenatal care: Effect of physical violence

Author	Seger, S. M.
Journal/Affiliation	Journal of Nurse Midwifery
Publication Date	Mar/Apr 1998
Comments	One page synopsis of a study showing that women entering prenatal care late were more likely to report physical violence.

ID: 31
Document Title Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence

Author	Moore, M; Zaccaro, D.; Parsons, L. H.
Journal/Affiliation	Journal of Obstetric, Gynecologic, and Neonatal Nursing
Publication Date	Mar/Apr 1998
Comments	Descriptive study of education, attitudes, and practices related to domestic violence in perinatal nurses practicing in 3 different settings. Lack of training and time were most frequent barriers. Education did change practice.

ID: 32
Document Title Preventing abuse during pregnancy: A clinical protocol

Author	McFarlane, J.; Gondolf, E.
Journal/Affiliation	The American Journal of Maternal Child Nursing
Publication Date	Jan/Feb 1998
Comments	Protocol for assessment of and intervention in abuse during pregnancy from the NursingCenter.com.

ID: 33

Document Title Parental screening for intimate partner violence by pediatricians and family physicians

Author Borowsky Iris, Wagman; Ireland, Marjorie

Journal/Affiliation Pediatrics

Publication Date Sep 2002

Comments Evaluation of screening conducted by pediatricians and family physicians. Factors that increase the likelihood of screening for IPV are a family physician, female, older, with practice in an urban area. Residency training in prevention of child/adolescent violence (not medical school), and continuing medical education were also factors.

ID: 34

Document Title Making family planning clinics an empowerment zone for rural battered women

Author Ulbrich, Patricia; Stockdale, Jami

Journal/Affiliation Women & Health

Publication Date 2002

Comments Evaluation of implementing domestic violence screening using questionnaires from staff and activity reports of on-site medical advocate. Changes in self-reported knowledge and practice suggest the training and tools provided to implement the RADAR model were effective. Increase in reported comfort but some issues are still problematic for the staff.

ID: 35

Document Title The impact of perceived barriers on primary care physicians' screening practices for female partner abuse

Author Chamberlain, Linda; Perham-Hester Katherine, A.

Journal/Affiliation Women & Health

Publication Date 2002

Comments Examined primary care physicians' screening practices for partner abuse in Alaska. Most physicians will screen often or always when a patient presents for injury but do not screen routinely at initial or annual visits. Physicians' perception of abuse is a key factor in decision to screen.

ID: 36
Document Title Violence in the lives of young women: Clinical care and management

Author	Rickert, V.I; Edwards, S.; Harrykissoon, S. D; Wiemann, C.M.
Journal/Affiliation	Current Women's Health Reports
Publication Date	Oct 2001
Comments	Advice on risk factors and sequelae associated with interpersonal violence, and of specific screening tools and procedures designed to detect violence for clinicians.

ID: 37
Document Title Intimate partner violence: Implications for nursing

Author	Walton-Moss, Benita; Campbell, Jacquelyn
Journal/Affiliation	Online Journal of Issues in Nursing Electronic Resource
Publication Date	2002
Comments	Reviews past literature addressing epidemiology, identification, and screening, and interventions for IPV. Role of nurses in assessment, documentation and making a safety plan is discussed.

ID: 38
Document Title Clinical screening and intervention in cases of partner violence

Author	Griffin, Michael, P.; Kossn Mary, P.
Journal/Affiliation	Online Journal of Issues in Nursing Electronic Resource
Publication Date	2002
Comments	Discusses screening of IPV and a tool (RADAR) for screening by nurses. RADAR: Remember, Ask, Document, Assess and Review is also a guideline for nurses.

ID: 39

Document Title Lifetime and current abuse, pregnancy risks, and outcomes among Native American women

Author Bohn, Diane

Journal/Affiliation Journal of Health Care for the Poor and Underserved

Publication Date May 2002

Comments Study examined relationship between abuse and pregnancy outcomes and care among Native American Women. Found relationship with inadequate prenatal weight gain and decreases birth weight.

ID: 40

Document Title Prevalence and patterns of intimate partner violence among adolescent mothers during the postpartum period

Author Harrykissoon, Samantha; Rickert, Vaughn; Wiemann Constance

Journal/Affiliation Archives of Pediatrics & Adolescent Medicine

Publication Date Apr 2002

Comments Assesses prevalence, frequency and patterns of IPV among postpartum adolescent mothers.

ID: 41

Document Title Barriers to disclosure of abuse among rural women

Author Kershner, Marion; Anderson, Jon

Journal/Affiliation Minnesota Medicine

Publication Date Mar 2002

Comments Research addressed characteristics related to abuse, extent of screening for abuse by health care providers, and barriers to disclosing abuse.

ID: 42

Document Title Continuing education about physically abusive relationships: Does education change the perceptions of health care practitioners?

Author Perrin, K.M; Boyett, T. R; McDermott, R. J.

Journal/Affiliation Journal of Continuing Education in Nursing

Publication Date Nov/Dec 2000

Comments Assessed effectiveness of mandatory continuing education on health care professionals' screening practices for IPV. Healthcare professionals perception, awareness, and recognition was not changed by the biennial mandatory continuing education regarding domestic violence.

ID: 43

Document Title Screening for abuse: Barriers and opportunities

Author D'Avolio, D.; Hawkins, J.W; Haggerty, L. A; Kelly, U; Barrett, R.; Durno, Toscano S E; Dwyer, J.; Higgins, L.P; Kearney, M.; Pearce, C. W; Aber, C.; Mahony, D.; Bell, M.

Journal/Affiliation Health Care for Women International

Publication Date Jun 2001

Comments Part of a larger project looking at women's psychological and behavioral responses to abuse affect birth. Program screened every pregnant women at 8 prenatal clinics. Training of all persons at each site but screening remained inconsistent even after retraining.

ID: 45

Document Title Sexual abuse and sexual risk behaviors of minority women with sexually transmitted diseases

Author Champion, J. D; Shain, R.; Piper, J.; Perdue, S. T

Journal/Affiliation Western Journal of Nursing Research

Publication Date Apr 2001

Comments Relationship between sexual abuse, risk behaviors, and risk for reinfection among minority women with STD's. Emphasized the need to assess for sexual abuse in STD/HIV prevention programs.

ID: 46

Document Title Reproductive health consequences of intimate partner violence: A nursing research review

Author Campbell, J. C; Woods, A. B; Chouaf, K. L; Parker, B.

Journal/Affiliation Clinical Nursing Research

Publication Date Aug 2000

Comments Literature review of nursing research on IPV and reproductive health. Also discusses some nursing interventions and concludes with clinical implications.

ID: 47

Document Title Abuse during and before pregnancy: Prevalence and cultural correlates

Author Torres, S.; Campbell, J.; Campbell, D.; Ryan, J.; King, C.; Price, P.; Stallings, R.; Fuchs, S.; Laude, M.

Journal/Affiliation Violence and Victims

Publication Date Fall 2000

Comments Study examines prevalence of abuse during pregnancy and cultural norms/attitudes about abuse in a multiethnic group. Results of this study strongly reinforce the necessity of differentiating within racial categories and considering acculturation and cultural norms as well as ethnicity in research and practice.

ID: 48

Document Title Screening for domestic violence during pregnancy

Author Saunders, E. E

Journal/Affiliation International Journal of Trauma Nursing

Publication Date Apr/Jun 2000

Comments Describes a careful approach to screening all pregnant trauma patients to help clinicians with assessment for intentional trauma.

ID: 50

Document Title Opportunities for intervention: Discussing physical abuse during prenatal care visits

Author	Durant, T.;Colley, Gilbert; Saltzman, L; Johnson, C.
Journal/Affiliation	American Journal of Preventive Medicine
Publication Date	Nov 2000
Comments	Assessed the prevalence of and factors associated with physicians' screening for physical abuse.

ID: 51

Document Title Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting

Author	Brown, J. B.; Lent, B.; Schmidt, G.; Sas, G.
Journal/Affiliation	Journal of Family Practice
Publication Date	Oct 2000
Comments	Evaluation of the validity and reliability of a WAST screening tool for IPV, as well as its efficacy for physicians and patients being screened. WAST consisted of 7 questions, but an 8th was added asking about sexual abuse. Found to have a high internal consistency and a demonstrated construct validity. The WAST-Short includes the first 2 questions of the WAST.

ID: 52

Document Title Future directions for violence against women and reproductive health: Science, prevention, and action

Author	Campbell, J. C; Moracco, K. E; Saltzman, L.
Journal/Affiliation	Maternal and Child Health Journal
Publication Date	Jun 2000
Comments	Paper briefly summarizes the history of the nexus of public health, health care, and violence against women.

ID: 53
Document Title Violence and reproductive health: Current knowledge and future research directions

Author	Gazmararian, J. A; Petersen, R.; Spitz, A. M; Goodwin, M. M; Saltzman, L. E; Marks, J.
Journal/Affiliation	Maternal and Child Health Journal
Publication Date	Jun 2000
Comments	Commentary and brief review of literature on violence and reproductive health. Offers recommendations for future research.

ID: 54
Document Title Influence of abuse and partner hypermasculinity on the sexual behavior of Latinas

Author	Suarez-Al-Adam, M.; Raffaelli, M.; O'Leary, A.
Journal/Affiliation	AIDS Education and Prevention
Publication Date	Jun 2000
Comments	Investigated abuse and partner hypermasculinity among Latinas. Took part in a brief intervention that showed few outcomes.

ID: 55
Document Title Fear and violence: Raising the HIV stakes

Author	El-Bassel, N.; Gilbert, L.; Rajah, V.; Foleno, A.; Frye, V.
Journal/Affiliation	AIDS Education and Prevention
Publication Date	Apr 2000
Comments	Qualitative Study (focus groups) exploring the relationship between IPV and HIV risk-behavior in substance abusers.

ID: 56

Document Title Should children be in the room when the mother is screened for partner violence?

Author Zink, T.

Journal/Affiliation Journal of Family Practice

Publication Date Feb 2000

Comments Qualitative study examined the issue of having children present when screening women for IPV and the coexistence of child abuse and domestic violence.

ID: 57

Document Title Mexican and Mexican American women in a battered women's shelter: Barriers to condom negotiation for HIV/AIDS prevention

Author Davila, Y. R; Brackley, M.

Journal/Affiliation Issues in Mental Health Nursing

Publication Date Jul/Aug 1999

Comments Qualitative study exploring barriers to condom negotiation among Mexican and Mexican American women in abusive relationships. Utilized demographic form, the Domestic Violence Assessment Form (McFarlane), and a semistructured interview guide developed for this study. Women who experience male partner power and control over their daily life experiences and behaviors may not be in a position to successfully initiate condom negotiation for HIV/AIDS prevention.

ID: 58

Document Title Intimate partner violence and HIV risk among urban minority women in primary health care settings

Author Wu, Elwin; El-Bassel, Nabila; Witte, Susan S.; Gilbert, Louisa; Chang, Mingway

Journal/Affiliation AIDS & Behavior

Publication Date Sep 2003

Comments Examine the relationships between IPV and several sexual HIV risk-related factors with ~1600 minority women.

ID: 59
Document Title Changing Women's Lives: The Primary Prevention of Violence Against Women

Author	King, Christine;Campbell, Jacquelyn C. (Ed).
Journal/Affiliation	Empowering Survivors of Abuse: Health Care for Battered Women and their Children
Publication Date	1998
Comments	Overview of domestic violence with section providing recommendations for screening and prevention.

ID: 60
Document Title Intimate partner violence, HIV status, and sexual risk reduction

Author	Gielen, Andrea Carlson; McDonnell, Karen A.; O'Campo, Patricia J.
Journal/Affiliation	AIDS & Behavior
Publication Date	Jun 2002
Comments	Association between IPV and HIV and other factors. Majority of women experience some form of IPV. HIV status not a significant correlate, but partner characteristics were. Women at increased risk for current, frequent IPV had partners who were more likely to have problems with alcohol and drug use and whose HIV status was different from their own or was unknown to them.

ID: 61
Document Title Violence During Pregnancy Among Women With or at Risk for HIV Infection

Author	Koenig, Linda J.; Whitaker, Daniel J.; Royce, Rachel A.; Wilson, Tracey E.; Callahan, Michelle R.; Fernandez, M. Isabel
Journal/Affiliation	American Journal of Public Health
Publication Date	Mar 2002
Comments	Estimates prevalence of violence during pregnancy in relation to HIV infection. HIV-positive women were likely to experience violence but not likely to be related to their serostatus.

ID: 62

Document Title Health Care Professionals' Skills, Beliefs, and Expectations About Screening for Domestic Violence in a Border Community

Author Goff, Heather Woodworth; Byrd, Theresa L.; Shelton, Andrea J.; Parcel, Guy S.

Journal/Affiliation Family & Community Health

Publication Date Apr 2001

Comments Determines association between physician education and screening practices. Significant associations existed between education and preparedness, beliefs about how and when to screen, and positive and realistic outcome expectations.

ID: 63

Document Title Identifying Abused Childbearing Women: Methodological Approaches

Author Rice, Michael J.; Records, Kathie

Journal/Affiliation National Academies of Practice Forum: Issues in Interdisciplinary Care

Publication Date Jan 2000

Comments Describes a physiological marker for assessment of the presence of abuse. Reviews literature and also describes common violence screening tools.

ID: 64

Document Title Predictive Models of Domestic Violence and Fear of Intimate Partners Among Migrant and Seasonal Farm Worker Women

Author Van Hightower, Nikki R.; Gorton, Joe; DeMoss, Casey Lee

Journal/Affiliation Journal of Family Violence

Publication Date Jun 2000

Comments Study examines prevalence of abuse among migrant farm workers and predictors of victimization. Strongest predictors of abuse were drug/alcohol use by partner, pregnancy and migrant status.

ID: 65

Document Title Physician's Beliefs About Victims of Spouse Abuse and About the Physician's Role

Author	Garimella, Ramani; Plichta, Stacey B.; Houseman, Clare; Garzon, Laurel
Journal/Affiliation	Journal of Women's Health & Gender-Based Medicine
Publication Date	May 2000
Comments	Study assessed physicians' beliefs about spouse abuse and their ability to assist victims. Most felt that lacked training to respond. Appears that didactic training does not provide much opportunity for physicians to practice interventions or gain a sense of competency.

ID: 66

Document Title Characteristics of Sexual Abuse Against Pregnant Hispanic Women by Their Male Intimates

Author	McFarlane, Judith; Wiist, William; Watson, Mary
Journal/Affiliation	Journal of Women's Health
Publication Date	Aug 1998
Comments	Describes the type and frequency of male intimate sexual abuse reported by pregnant Hispanic women receiving prenatal care in urban public health clinics.

ID: 67

Document Title Violence and HIV Sexual Risk Behaviors Among Female Sex Partners of Male Drug Users

Author	He, Haiou; McCoy, H. Virginia; Stevens, Sally J.; Stark, Michael J.
Journal/Affiliation	Women & Health
Publication Date	1998
Comments	Examined prevalence of sexual and physical abuse of female partners of male drug users and the association between violence and HIV-related risk behaviors.

ID: 68

Document Title Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African American Women

Author Kalichman, Seth C.; Williams, Ernestine A.; Cherry, Charsey; Belcher, Lisa; Nachimson, Dena

Journal/Affiliation Journal of Women's Health

Publication Date Apr 1998

Comments Survey examined sexual coercion and physical abuse among low income women and relationship to drug use and HIV risk behaviors. Women experience constellation of problems that put them at risk for HIV.

ID: 69

Document Title Screening for intimate partner violence when children are present - the victim's perspective

Author Zink, T. M.; Jacobson, J.

Journal/Affiliation Journal of Interpersonal Violence

Publication Date 2003

Comments Qualitative examination of women's views on screening for IPV when their children are present. Provides recommendations for clinician behavior depending on age of the child.

ID: 70

Document Title Adolescents' experiences of dating and intimate partner violence: 'Once is not enough'

Author Scheiman, L.; Zeoli, A. M.

Journal/Affiliation Journal of Midwifery & Women's Health

Publication Date 2003

Comments Case study followed by screening recommendations for clinicians.

ID: 71

Document Title Adolescent dating violence: Prevalence, risk factors, health outcomes, and implications for clinical practice

Author Glass, N.; Fredland, N.; Campbell, J.; Yonas, M.; Sharps, P.; Kub, J.

Journal/Affiliation Journal of Obstetric Gynecologic and Neonatal Nursing

Publication Date Mar/Apr 2003

Comments Literature review provides an assessment of dating violence in adolescence.

ID: 72

Document Title Experiences of seeking help from health professionals in a sample of women who experienced domestic violence

Author Bacchus, L.; Mezey, G.; Bewley, S.

Journal/Affiliation Health & Social Care in the Community

Publication Date 2003

Comments Qualitative evaluation of abused women's experiences seeking help from health professionals and their psychological health.

ID: 73

Document Title Measuring the quality of hospital-based domestic violence programs

Author Coben, J. H.

Journal/Affiliation Academic Emergency Medicine

Publication Date 2002

Comments Used Delphi Process to determine performance measures useful in evaluating hospital-based domestic violence programs. Through consensus development, a number of measures were identified as useful for evaluating the quality of hospital based DV programs.

ID: 74

Document Title Domestic violence compared to other health risks a survey of physicians' beliefs and behaviors

Author Gerbert, B.; Gansky, S. A.; Tang, J. W.; Mcphee, S. J.; Carlton, R.; Herzig, K.; Danley, D.; Caspers, N.

Journal/Affiliation American Journal of Preventive Medicine

Publication Date 2002

Comments Assesses physicians' beliefs and practices regarding screening for domestic violence with ~610 physicians. Physicians' behaviors and beliefs on screening and intervention for DV differ from those for tobacco use, alcohol abuse and HIV/STD. They are not screening for DV at the level they screen for other health risks.

ID: 75

Document Title Intimate partner violence and high-risk sexual behaviors among female patients with sexually transmitted diseases

Author Bauer, H. M.; Gibson, P.; Hernandez, M.; Kent, C.; Klausner, J.; Bolan, G.

Journal/Affiliation Sexually Transmitted Diseases

Publication Date 2002

Comments Examined IPV among STD patients. IPV is common and associated with risk behaviors and partner factors.

ID: 76

Document Title Provider evaluation of a multifaceted system of care to improve recognition and management of pregnant women experiencing domestic violence

Author Zachary, M. J.; Schechter, C. B.; Kaplan, M. L.; Mulvihill, M. N.

Journal/Affiliation Women's Health Issues

Publication Date 2002

Comments Evaluation of a DV curriculum using baseline and follow-up provider surveys and a qualitative assessment of medical providers' experiences and perceptions with the intervention.

ID: 77
Document Title Predictive validity of a screen for partner violence against women

Author	Koziol-Mclain, J.; Coates, C. J.; Lowenstein, S. R.
Journal/Affiliation	American Journal of Preventive Medicine
Publication Date	2001
Comments	Assesses predictive value of a brief screening tool for IPV. Violence Screen with 3 questions about physical violence and sexual coercion by an intimate partner, feelings of fear, and escalated fights or arguments.

ID: 78
Document Title Identification and management of domestic violence - a randomized trial

Author	Thompson, R. S.; Rivara, F. P.; Thompson, D. C.; Barlow, W. E.; Sugg, N. K.; Maiuro, R. D.; Rubanowice, D. M.
Journal/Affiliation	American Journal of Preventive Medicine
Publication Date	2000
Comments	Evaluation of the effectiveness on an intervention to improve screening for domestic violence. Intense intervention with modest effects.

ID: 79
Document Title A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims

Author	Gerbert, B.; Caspers, N.; Bronstone, A.; Moe, J.; Abercrombie, P.
Journal/Affiliation	Annals of Internal Medicine
Publication Date	1999
Comments	Describes how providers in one geographic area identify and intervene with IPV. This study highlights the fact that the development and implementation of a standardized screening protocol for DV has not eased the difficulty of identifying victims in health care settings.

ID: 80
Document Title How health care providers help battered women: The survivor's perspective

Author	Gerbert, B.; Abercrombie, P.; Caspers, N.; Love, C.; Bronstone, A.
Journal/Affiliation	Women & Health
Publication Date	1999
Comments	Qualitative study examined what helped victims when being screened in health care encounters. The manner in which providers screen for domestic violence may be even more important than directly identifying victims.

ID: 81
Document Title Domestic violence in women

Author	Elbayoumi, G.; Borum, M. L.; Haywood, Y.
Journal/Affiliation	Medical Clinics of North America
Publication Date	1998
Comments	Review of the scope of domestic violence, ways to recognize and manage abuse, and its potential impact on health. Gives some guidelines on screening.

ID: 84
Document Title Interventions for Violence Against Women

Author	Wathen, C. Nadine; MacMillan, Harriet L.
Journal/Affiliation	Journal of the American Medical Association
Publication Date	Feb 2003
Comments	Systematic review of literature assessing evidence on abuse prevention interventions, including screening for abuse.

ID: 85
Document Title Interventions for Intimate Partner Violence Against Women

Author	Rhodes, Karin V.; Levinson, Wendy
Journal/Affiliation	Journal of the American Medical Association
Publication Date	Feb 2003
Comments	Case studies of interventions for patients and physicians with suggestions for screening and care.

ID: 86
Document Title Should health professionals screen women for domestic violence?

Author	Ramsay, Jean; Richardson, Jo; Carter, Yvonne H.; Davidson, Leslie L.; Feder, Gene
Journal/Affiliation	British Medical Journal
Publication Date	Aug 2002
Comments	Systematic review of studies examining the evidence for effectiveness of screening for domestic violence in healthcare settings. Concludes that evidence of benefits is insufficient to recommend universal screening.

ID: 87
Document Title Domestic Violence: The Challenge for Nursing

Author	Draucker, Claire Burke
Journal/Affiliation	Online Journal of Issues in Nursing
Publication Date	Jan 2002
Comments	Overview of IPV and its consequences from a nursing perspective.

ID: 89
Document Title Effective Advocacy on Behalf of Battered Women

Author Frederick, Lorretta
Journal/Affiliation Battered Women's Justice Project
Publication Date
Comments

ID: 90
Document Title Diagnostic and Treatment Guidelines on Domestic Violence

Author American Medical Association
Journal/Affiliation
Publication Date
Comments Recommends IPV screener questions & approaches for physicians. Provides diagnosis & clinical findings common to IPV including common types of injury & mental, psychiatric & behavioral symptoms. Provides guidelines on physician documentation.

ID: 91
Document Title Evaluating Coordinated Community Responses to Domestic Violence

Author Shephard, Melanie
Journal/Affiliation VAW Net Applied Research Forum
Publication Date Apr 1999
Comments

ID: 92
Document Title Domestic Abuse in Later Life

Author	Brandl, B.; Cook-Daniels, L.
Journal/Affiliation	VAW Net Applied Research Forum
Publication Date	Dec 2002
Comments	Literature review of research in IPV later in life.

ID: 93
Document Title Marital Rape

Author	Bergen, Raquel Kennedy
Journal/Affiliation	VAW Net Applied Research Forum
Publication Date	Mar 1999
Comments	Literature review of research in marital rape.

ID: 94
Document Title The Overlap Between Child Maltreatment and Women Abuse

Author	Edleson, Jefferey
Journal/Affiliation	VAW Net Applied Research Forum
Publication Date	Apr 1999
Comments	Brief review of literature on convergence of child abuse and IPV.

ID: 95
Document Title Prevention of Domestic Violence and Sexual Assault

Author Wolfe, D.; Jaffe, P.
Journal/Affiliation VAW Net Applied Research Forum
Publication Date Jan 2003
Comments

ID: 96
Document Title Substance Abuse and Women Abuse by Male Partners

Author Bennett, Larry
Journal/Affiliation VAW Net Applied Research Forum
Publication Date Feb 1998
Comments Internet based literature review. Briefly covers drug abuse and IPV.

ID: 97
Document Title Welfare and Domestic Violence Against Women

Author Lyon, Eleanor
Journal/Affiliation VAW Net Applied Research Forum
Publication Date Aug 2002
Comments Brief web-based literature review.

ID: 98
Document Title Remembering Who We Work For: Advocacy and the Battered Women's Movement

Author	Avalon, Stephanie
Journal/Affiliation	Reform, A-files
Publication Date	Oct 1999
Comments	Brief web-based literature review.

ID: 99
Document Title Advocacy In a Coordinated Community Response: Overview and Highlights of Three Programs

Author	Thelan, Rose
Journal/Affiliation	Gender Violence Institute
Publication Date	
Comments	

ID: 100
Document Title Confidentiality and Information–Sharing Within a Coordinated Community Response

Author	Frederick, L.; Lizdas, K.
Journal/Affiliation	Battered Women's Justice Project
Publication Date	
Comments	Concerns legal issues of women's confidentiality around community referral system.

ID: 101
Document Title Documenting Domestic Violence: How Health Care Providers can Help Victims

Author Isaac, N.; Enos, P.
Journal/Affiliation National Institute of Justice Research in Brief
Publication Date Sep 2001
Comments Guidelines for documenting abuse correctly so that they can be used in legal proceedings.

ID: 102
Document Title Domestic Violence Awareness Handbook

Author USDA Safety, Health and Employee Welfare Division
Journal/Affiliation
Publication Date
Comments

ID: 103
Document Title Domestic violence screening practices of obstetrician-gynecologists

Author Horan, D.; Chapin, J.; Klein, L.; Schmidt, L.; Schulkin, J.
Journal/Affiliation Obstetrics & Gynecology
Publication Date Nov 1998
Comments Ascertains the current knowledge base and screening practices of [OB-GYNs] in the area of domestic violence.

ID: 104
Document Title Addressing Domestic Violence in a Clinical Setting

Author Migrant Clinician's Network
Journal/Affiliation
Publication Date 2002
Comments Provides health care workers of migrant and immigrant women a manual for addressing domestic violence in a clinical setting. Give an understanding of the issues unique to this population and stresses importance of screening and documentation.

ID: 105
Document Title Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

Author Aravanis, S.; Adelman R.; Breckman, R.; Fulmer, T.; Holder, E.; Lachs, M.; O'Brien, J.; Sanders, A.
Journal/Affiliation American Medical Association Guidelines
Publication Date Oct 1992
Comments Includes facts about elder mistreatment; interviewing guidelines; diagnosis and clinical findings; assessment.
intervention, and case management. Also covers documentation and legal considerations; risk management; trends in treatment and prevention with information about resources and agencies.

ID: 106
Document Title Intimate and Caregiver Violence Against Women with Disabilities

Author Erwin, Patricia
Journal/Affiliation Dept of Criminology, UC, Irvine
Publication Date July 2000
Comments

ID: 107
Document Title Evaluating Domestic Abuse Programs

Author	Coben, Jeffrey
Journal/Affiliation	Agency for Healthcare Research and Quality (AHRQ)
Publication Date	Sep 2002
Comments	Attempts to improve the health care response to victims of domestic violence by providing a tool to evaluate the quality of health care and the quality of health care interventions for domestic violence using a health services research paradigm.

ID: 108
Document Title Family Dysfunction and Native American Women Who do Not Seek Prenatal Care

Author	Tyson, H; Higgins, R.; Tyson, I.
Journal/Affiliation	Archives of Family Medicine
Publication Date	1999
Comments	Examines whether women with no prenatal care have higher rates of nuclear family dysfunction and disproportionate amounts of adverse neonatal outcomes compared with women with prenatal care.

ID: 110
Document Title Domestic Violence in the Farm Worker Population: Monograph

Author	Van Hightower, N.; Dorsey, A.
Journal/Affiliation	Migrant Clinician's Network
Publication Date	May 2001
Comments	Evaluation of research using migrant farm worker women as interviewers for a domestic violence survey. Percentage of women reporting domestic violence was more than double previous MCN survey.

ID: 113
Document Title Handbook for Survivors of Sexual Assault

Author	Michigan Coalition Against Domestic and Sexual Violence
Journal/Affiliation	
Publication Date	
Comments	Handbook prepared with the purpose of providing accurate information regarding the medical and legal concerns, as well as to discuss issues regarding physical and emotional healing.

ID: 114
Document Title Evaluating Programs for Batterers

Author	Nichols, Brian
Journal/Affiliation	Men Stopping Violence
Publication Date	2001
Comments	Focuses on programs for batterers.

ID: 115
Document Title Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence

Author	Goldman L.; Horan D.; Warshaw C.; Kaplan S.; Hendricks-Matthews M.
Journal/Affiliation	American Medical Association
Publication Date	Oct 1995
Comments	Addresses the psychological and behavioral impact of family violence. Defines physician's responsibility to consider, recognize, evaluate and offer interventions or referrals for mental health problems associated with family violence.

ID: 116
Document Title Domestic Violence: A Practical Approach for Clinicians

Author	Heilig, S.; Rodriquez, M.; Martin, S.; Louie, D.
Journal/Affiliation	San Francisco Medical Society
Publication Date	
Comments	A brochure summarizing existing knowledge and guidelines for the screening, treatment, and prevention of domestic violence in various clinical settings.

ID: 117
Document Title Ending Violence Against Women

Author	Center for Health and Gender Equity
Journal/Affiliation	Population Reports, Series L
Publication Date	Dec 1999
Comments	Teaches health care providers how to ask clients about violence, become better aware of signs that can identify victims of DV or sexual abuse, and help women protect themselves by developing a personal safety plan.

ID: 118
Document Title Professional, Ethical, and Legal Issues Concerning Interpersonal Violence, Maltreatment, and Related Trauma

Author	American Psychological Association
Journal/Affiliation	
Publication Date	
Comments	Focused on intervention and response to DV from the psychological practice point of view.

ID: 119
Document Title Working Effectively with the Police: A Guide for Battered Women's Advocates

Author Sadusky, Jane
Journal/Affiliation Violence Against Women Office, DOJ
Publication Date Aug 2001
Comments Guidelines focused on intervention and response to domestic violence and working with justice system. Geared toward advocates.

ID: 120
Document Title Physician's Reference Card: Recognizing and Treating Victims of Domestic Violence

Author New York State Department of Health Office for the Prevention of Domestic Violence
Journal/Affiliation
Publication Date 2003
Comments Provides a reference card for physicians outlining the protocol for recognizing and treating victims of domestic violence.

ID: 121
Document Title Get Help Series: Domestic Violence

Author The National Center for Victims of Crime
Journal/Affiliation
Publication Date
Comments Overview of the issue of domestic violence, focus on the survivor, rather than the health care provider.

ID: 122
Document Title Domestic Violence Health Care Provider Training Evaluation Toolkit

Author Pennsylvania Coalition Against Domestic Violence
Journal/Affiliation
Publication Date
Comments Toolkit for use in assessment of training needs in the area of domestic violence for health care providers. Can use the toolkit to evaluate a range of healthcare trainings on domestic violence.

ID: 123
Document Title Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers

Author Warshaw, C.; Ganley, A.
Journal/Affiliation Family Violence Prevention Fund
Publication Date Mar 1996
Comments Resource manual includes guidelines on identification, assessment and intervention of domestic violence victims.

ID: 124
Document Title Screening Tools--Domestic Violence from American College of Obstetrics and Gynecology

Author American College of Obstetricians and Gynecologists
Journal/Affiliation
Publication Date 2003
Comments ACOG recommendations for screening for intimate partner violence. Provides tools and guidelines.

ID: 125
Document Title Family and Intimate Partner Violence Initiatives

Author Health Resources and Service Administration
Journal/Affiliation
Publication Date 2002
Comments

ID: 126
Document Title Healing Shattered Lives: Assessment of Selected Domestic Violence Programs in Primary Care Settings

Author Shannon, K.; Deighton, K.
Journal/Affiliation HRSA
Publication Date 2002
Comments

ID: 127
Document Title Intimate Partner Violence During Pregnancy: A Guide for Clinicians

Author American College of Obstetricians and Gynecologists
Journal/Affiliation Conference Presentation
Publication Date
Comments Guidelines for OB/GYN screening for intimate partner violence in pregnant women.

ID: 128
Document Title Red flags, predictors and things to watch

Author Oklahoma Coalition against Domestic Violence and Sexual Assault
Journal/Affiliation
Publication Date
Comments Identifies signs to watch for before abuse occurs and indicators of existing abuse.

ID: 129
Document Title The Military Response to Domestic Violence: Tools for Civilian Advocates

Author Beals, Judith E.
Journal/Affiliation Battered Women's Justice Project
Publication Date June 2003
Comments Starts from reporting abuse, does not cover screening but focuses on advocacy and intervention.

ID: 130
Document Title National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings

Author Family Violence Prevention Fund
Journal/Affiliation
Publication Date Sept 2002
Comments Recommendations on how screening for DV victimization, and assessment, documentation, intervention, and referrals should occur in multiple settings and in various professional settings.

ID: 131
Document Title National Crime Victimization Survey; Criminal Victimization, 2002

Author	Rennison, C.; Rand, M.
Journal/Affiliation	National Crime Journal
Publication Date	Aug 2003
Comments	National Crime Statistics for 2002, including rape/sexual assault and physical assault. Presents statistics according to race, marital status, and region, as well as by relationship of victims to perpetrators.

ID: 132
Document Title The Need to Consider Characteristics of Intimate Partner Violence When Designing an Intervention to Increase Condom Use Among HIV-Positive and HIV-Negative Women

Author	Gielen, AC; McDonnell, KA; O'Campo, P; Burke JG
Journal/Affiliation	National HIV Prevention Conference (Presentation)
Publication Date	1999
Comments	Presentation abstract - examines association between HIV status, current abuse and partner characteristics.

ID: 133
Document Title A Protocol on Safety: Research on Abuse of Women

Author	Parker, B; Ulrich, Y.
Journal/Affiliation	Nursing Research Consortium on Violence and Abuse
Publication Date	July/Aug 1990
Comments	Guidelines for research on abuse of women to protect the research subjects, the researcher, and the data.

ID: 134
Document Title Partner Violence: How to Recognize and Treat Victims of Abuse

Author	Alpert, Elaine J.
Journal/Affiliation	A Guide for Physicians and Other Health Care Professionals
Publication Date	Aug 1999
Comments	Guide developed to help physicians and other health care professionals improve ability to respond to the needs of patients who have experienced partner violence.

ID: 135
Document Title Physical Abuse of Women Before, During, and After Pregnancy

Author	Martin, S; Mackie L; Kupper L; Buescher P; Moracco K
Journal/Affiliation	Journal of the American Medical Association
Publication Date	Mar 2001
Comments	Examines the prevalence and patterns of physical abuse before, during, and after pregnancy. Women who are physically abused before and/or during pregnancy are likely to experience abuse after delivery, placing the health of both mother and child at risk.

ID: 136
Document Title Who Gets Screened During Pregnancy for Partner Violence?

Author	Clark K; Martin S; Petersen R; Cloutier S; Covington D; Buescher P; Beck-Warden M
Journal/Affiliation	Archives of Family Medicine
Publication Date	Nov/Dec 2000
Comments	Extends past research by examining prenatal screening for partner violence in a representative sample of postnatal women. Women who received public funding for care were more than 4 times the odds of screening among women with a private provider and insurance.

ID: 137
Document Title Preventing Domestic Violence: Clinical Guidelines on Routine Screening

Author Family Violence Prevention Fund
Journal/Affiliation
Publication Date Oct 1999
Comments Recommendations on how screening should occur within the healthcare system, including assessment, intervention, documentation, and referral.

ID: 138
Document Title RADAR: A Domestic Violence Intervention

Author Office for the Prevention of Domestic Violence
Journal/Affiliation
Publication Date
Comments A tool for Domestic Violence intervention.

ID: 139
Document Title Strategies for the Treatment and Prevention of Sexual Assault

Author American Medical Association
Journal/Affiliation
Publication Date Oct 1995
Comments Reviews physician's roles and responsibilities in regard to sexual assault.

ID: 140
Document Title Ending Violence Against Women

Author	Heise, L.; Ellsberg M.; Gottemoeller M.
Journal/Affiliation	Population Reports
Publication Date	Dec 1999
Comments	Reviews DV and related issues with an international focus. Chapt. 6 discusses health care response, including screening. Sidebars include examples of successful programs.

ID: 142
Document Title Domestic Violence and Welfare Benefits

Author	Fromson T; Sorrentino L; Hirsch A; Whitelaw J; Blazer J; Zurflieh P
Journal/Affiliation	Pennsylvania Coalition Against Domestic Violence
Publication Date	2003
Comments	Focus on victims of domestic violence. Very little information on prevention or screening.

ID: 146
Document Title Routine Screening for Intimate Partner Violence in an Obstetrics and Gynecology Clinic

Author	Scholle, Sarah; Buranosky, Raquel; Hanusa, Barbara; Ranieri, LeeAnn; Dowd, Kate; Valappil, Benita
Journal/Affiliation	American Journal of Public Health
Publication Date	July 2003
Comments	Examines frequency of intimate partner violence screening and disclosure in an outpatient obstetrics and gynecology clinic with a policy calling for routine screening at every visit. Used chart review. A number of useful findings.

ID: 147

Document Title Dating Violence In Mid-Adolescence: Theory, Significance, and Emerging Prevention Initiatives

Author Wekerle, Christine; Wolfe, David

Journal/Affiliation Clinical Psychology Review

Publication Date 1999

Comments Reviews theoretical and empirical work on adolescent dating and dating violence and 6 relationship violence prevention programs designed for and delivered to youth.

ID: 148

Document Title Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail

Author Worth, Dooley

Journal/Affiliation Studies in Family Planning

Publication Date 1989

Comments Discusses sexual risk taking among inner city American women whose risk of HIV infection is primarily related to their own or their partners' IV drug use.

ID: 149

Document Title Love, Sex and Power: Considering Women's Realities in HIV Prevention

Author Amaro, Hortensia

Journal/Affiliation American Psychologist

Publication Date 1995

Comments Examines how existing models of HIV behavioral risk reduction used in understanding sexual risk behaviors have been hampered by the lack of attention to gender and suggests factors that should be considered in behavioral theories that guide HIV prevention programs.

ID: 150

Document Title Forced Sex and Intimate Partner Violence: Effects on Women's Risk and Women's Health

Author Campbell, Jacquelyn; Soeken Karen L

Journal/Affiliation Violence Against Women

Publication Date 1999

Comments Examined the effects of forced sex in battering relationships with African-American women.

ID: 151

Document Title The Intersections of HIV and Violence: Directions for Future Research and Interventions

Author Maman, Suzanne; Campbell, Jacquelyn; Sweat, Michael D; Gielen, Andrea C

Journal/Affiliation Social Science and Medicine

Publication Date 2000

Comments Reviews the available literature on the intersections between HIV and violence and present an agenda for future research to guide policy and programs.

ID: 152

Document Title Partner Violence and Sexual HIV-Risk Behaviors Among Women in an Inner-City Emergency Department

Author El-Bassel, Nabila; Gilbert, Louisa; Krishnan, Satya; Schilling, Robert F; Gaeta, Theodore; Purpura, Stacey; Witte, Susan S

Journal/Affiliation Violence and Victims

Publication Date 1998

Comments Examines relationship between partner violence and sexual risk behavior in 143 African-American and Latina women.

ID: 153
Document Title Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence

Author Gielen, Andrea Carlson; McDonnell, Karen A; Burke, Jessica G; O'Campo, Patricia
Journal/Affiliation Maternal and Child Health Journal
Publication Date 2000
Comments Cross sectional study using interviews (qualitative and quantitative methods) to determine 1)the role HCPs play in women's disclosure to others of their HIV positive status, 2) women's experiences and concerns re disclosure, 3) the violence that women living with HIV experience and 4) how violence is related to diagnosis and disclosure.

ID: 154
Document Title What Happens After We Identify Intimate Partner Violence? The Family Physician's Perspective

Author Glowa, Patricia T; Frasier, Pamela Y; Wang, Lily; Eaker, Kathryn; Osterling, Wendy L
Journal/Affiliation Family Medicine
Publication Date Nov/Dec 2003
Comments Survey of family physicians to determine rates of asking about IPV, patient outcomes after disclosure, and changes in the doctor-patient relationship as a result of patient disclosure.

ID: 155
Document Title Women's Disclosure of HIV Status: Experiences of Mistreatment and Violence in an Urban Setting

Author Gielen, Andrea Carlson; O'Campo, Patricia; Faden, Ruth R; Eke, Agatha
Journal/Affiliation Women and Health
Publication Date 1997
Comments Describes women's fears and experiences regarding disclosure of their HIV status.

ID: 156

Document Title The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African American Women

Author Wingood, Gina M; DiClemente, Ralph J

Journal/Affiliation American Journal of Public Health

Publication Date 1997

Comments Examines the consequences of having a physically abusive primary partner on the condom use and sexual negotiation practices of young African American women.

ID: 157

Document Title Public Policy for Violence Against Women 30 Years of Successes and Remaining Challenges

Author Gelles, Richard J

Journal/Affiliation American Journal of Preventive Medicine

Publication Date 2000

Comments Commentary on Public Policy for Violence against women.

ID: 158

Document Title Screening for Family and Intimate Partner Violence: Recommendation Statement

Author US Preventive Services Task Force

Journal/Affiliation

Publication Date Mar 2004

Comments Summarizes the USPSTF recommendations on screening for family and intimate partner violence. USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for IPV, or of older adults or their caregivers for elder abuse.

ID: 159

Document Title Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers

Author Osattin, Alison; Short, Lynn M

Journal/Affiliation

Publication Date 1998

Comments Provides a resource for HCPs who seek training in the areas of intimate partner violence and sexual assault.

ID: 160

Document Title Development, Implementation and Challenges of a Universal Screening Tool for Intimate Partner Violence in an Urban Hospital

Author Harrington, Maura; Kubicek, Katrina; Splawn, Robert; Zupa, Rachel

Journal/Affiliation Presentation

Publication Date Oct 2004

Comments Conference presentation informing audience about development and validation of 3-question screening tool for use in emergency rooms. Discusses training staff, barriers to using and lessons learned.

ID: 161

Document Title Social Work Summit on Violence Against Women

Author Tomaszewski, Evelyn

Journal/Affiliation Equity

Publication Date Mar 2002

Comments Describes social work summit on domestic violence. Participants participated in working groups and made recommendations on 1) awareness and education, 2) prevention and intervention, 3) screening and assessment issues, and 4) public policy and social work policy.

ID: 162
Document Title Health Care System Responses to Children Exposed to Domestic Violence

Author	Culross, Patti L
Journal/Affiliation	Domestic Violence and Children
Publication Date	Winter 1999
Comments	Primarily focused on children's exposure but includes some discussion about DV without children involved, particularly reporting laws.

ID: 163
Document Title Better Health While You Wait: A Controlled Trial of a Computer-based Intervention for Screening and Health Promotion in the Emergency Department

Author	Rhodes, Karin V; Lauderdale, Diane S; Stocking, Carol; Howes, David; Roizen, Michael; Levinson, Wendy
Journal/Affiliation	Annals of Emergency Medicine
Publication Date	Mar 2001
Comments	Study examined use of computer intervention in emergency room to conduct screening and provide health education.

ID: 164
Document Title "Between Me and the Computer": Increased Detection of Intimate Partner Violence Using a Computer Questionnaire

Author	Rhodes, Karin V; Lauderdale, Diane S; He, Theresa; Howes, David S; Levinson, Wendy
Journal/Affiliation	Annals of Emergency Medicine
Publication Date	Nov 2002
Comments	Study about using computers to conduct IPV screening while patient waits. Detected more than control group but clinician behavior was important in process.

ID: 165

Document Title Responses of Male Inmates to Primary Partner Requests for Condom Use: Effects of Message Content and Domestic Violence History

Author Neighbors, Charles J; O'Leary, Ann

Journal/Affiliation AIDS Education and Prevention

Publication Date 2003

Comments Study with incarcerated men. They read scenarios of women asking man to use condoms, then indicated which ones would cause violence. Perceived infidelity was key.

ID: 166

Document Title Research on Domestic Violence in the 1990s: Making Distinctions

Author Johnson, Michael P; Ferraro, Kathleen J

Journal/Affiliation Journal of Marriage and the Family

Publication Date Nov 2000

Comments Review of violence research in 1990s. Does not focus on any clinical issues.

ID: 167

Document Title The State of Science: Violence and HIV Infection in Women

Author Manfrin-Ledet, Linda; Porche, Demetrius J

Journal/Affiliation Journal of the Association of Nurses in AIDS Care

Publication Date Nov/Dec 2003

Comments Review of literature on HIV and violence covering disclosure of diagnosis, similar risks for violence and HIV. Includes some advice for nurses.

ID: 168

Document Title Abused Women Report Greater Male Partner Risk and Gender-based Risk for HIV: Findings From a Community-based Study With Hispanic Women

Author Raj, A; Silverman, JG; Amaro, H

Journal/Affiliation AIDS Care

Publication Date May 2004

Comments Study with 170 Hispanic women. Reported high rate of IPV and HIV risk among abused women.

ID: 169

Document Title Domestic Violence: Screening Made Practical

Author Punukollu, Mallika

Journal/Affiliation Journal of Family Practice

Publication Date July 2003

Comments Advocacy paper encouraging physicians to screening for IPV. Provides HITS and WEBs scales and discusses other instruments.

ID: 170

Document Title What Situations Induce Intimate Partner Violence? A Reliability and Validity Study of the Proximal Antecedents to Violent Episodes (PAVE) Scale

Author Babcock, Julia; Costa, Daniela M; Green, Charles E

Journal/Affiliation Journal of Family Psychology

Publication Date 2004

Comments Development and validation of PAVE scale to identify situations that will provoke violent episode. Scales has 3 factors: violence to control, violence out of jealousy, and violence following verbal abuse.

ID: 171

Document Title Causal Attributions and Affective Responses to Provocative Female Partner Behavior by Abusive and Nonabusive Males

Author Moore, Todd M; Eisler, Richard M; Franchina, Joseph J

Journal/Affiliation Journal of Family Violence

Publication Date 2000

Comments Study examined the effect of female partner provocation on cognitive attributions and affective responses on violent and non-violent men.

ID: 172

Document Title Intimate Partner Violence and Physical Health Consequences: Policy and Practice Implications

Author Plichta, Stacey B

Journal/Affiliation Journal of Interpersonal Violence

Publication Date 2004

Comments Review of IPV and physical health consequences. Identifies gaps and offers suggestions for future research. Health care providers do not routinely screen for IPV.

ID: 173

Document Title STaT: A Three-Question Screen for Intimate Partner Violence

Author Paranjape, Anuradha; Liebschutz, Jane

Journal/Affiliation Journal of Women's Health

Publication Date Nov 2003

Comments Uses items from Index of Spousal abuse and Conflict Tactics Scale to develop 3-item scale.

ID: 174
Document Title Some Questions Regarding Spousal Assault Risk Assessment

Author Kropp, P Randall
Journal/Affiliation Violence Against Women
Publication Date June 2004
Comments Discusses risk assessment for spousal assault including defining risk, how assessments should be made, who should make the assessments and the role of the victim in the assessment. Non-clinical.

ID: 176
Document Title Directory of Projects Working to Eliminate Sexual Violence: A Directory of National Organizations and Projects

Author National Sexual Violence Resource Center
Journal/Affiliation
Publication Date May 2002
Comments A short document that lists the name and contact information of projects and organizations working to eliminate violence. Goals and products of each organization are included.

ID: 177
Document Title Improving Healthcare Response to Domestic Violence: An Information Packet for Health Care Providers

Author Family Violence Prevention Fund
Journal/Affiliation
Publication Date 2004
Comments Three page folderover for health care providers. Offers action steps, referral and resource information and facts about domestic violence.

ID: 178
Document Title Medical Care Utilization Patterns in Women With Diagnosed Domestic Violence

Author	Ulrich, Yvonne C; Cain, Kevin C; Sugg, Nancy K; Rivara, Frederick P; Rubanowice, David M; Thompson, Robert S
Journal/Affiliation	American Journal of Preventive Medicine
Publication Date	2003
Comments	Examined costs and medical care utilization patterns in women with DV. Women experiencing violence have higher rate of visits with corresponding higher costs.

ID: 179
Document Title Making the Connection: Domestic Violence and Public Health

Author	Chamberlain, L
Journal/Affiliation	Family Violence Prevention Fund Document
Publication Date	Jan 2004
Comments	Curriculum for providers working in public health settings (e.g., public health departments). Provides information for providers to recognize and respond to DV. It is not a skills-based curriculum but provides information about these.

Results from
Key Informant Interviews with State Title X Grantees and Regional Program Consultants

For the Project:

A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Selected Title X-supported Family Planning Clinics
Contract Number 282-98-0019
Task Order 13

Submitted to:

Pankaja Panda, PhD, MPH
Task Order Officer

Office of Population Affairs
US Department of Health and Human Services
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September 20, 2005

Submitted by:

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2.0 Methods

Two types of individuals were interviewed as off-site key informants – state Title X grantees and federal Regional Program Consultants. Nine state Title X grantees were invited to participate in the study because a Battelle study team had visited a clinic in their state. Each state was located in one of the ten DHHS regions with the exception of Region VIII. No clinic in that region that met the study criteria agreed to participate. In addition to state Title X grantees, federal Regional Program Consultants who oversaw the states with participating clinics were also asked to participate in the study. All of the state grantees and eight of the nine Regional Program Consultants agreed to be interviewed about FIPV prevention activities in their states or regions. One DHHS region was not represented because of staffing and time constraints.

Appendices A and B include the invitation letters sent to the state grantees and Regional Program Consultants inviting them to participate in the study via a telephone interview and explaining the topics that would be covered during the interview. Appendix C is a document that accompanied the invitation letter and explains the off-site key informants' rights as research participants. One to two weeks after these letters were sent, a member of the Battelle research team followed up with a telephone call to answer questions and schedule the interviews.

All interviews were completed in October and November of 2004 by one member of the research team using the interview guide attached in Appendix D. Interviews lasted approximately 30 minutes and were tape recorded and later transcribed. The transcripts were coded according to themes and concepts developed for this project and also used when analyzing the interviews with clinic directors and clinicians. Transcripts were initially coded by two individuals who met to reconcile differences in coding. Once 90% or better agreement was reached among the coders, all interviews were individually coded. The coding information was housed in a QSR N6© database, a qualitative data analysis software package. Each individual was given a unique identifying code according to their state and/or region. All other identifying information in the data was stripped and replaced by the identification codes or generic identifiers.

Reports were generated according to the codes and analyzed by a qualitative researcher and the Project Director.

3.0 Findings

The results of the off-site key informant interviews are presented below. Table 3.1 presents the interview findings arranged by the four areas of interest noted above. Section 3.1 discusses the challenges and Section 3.2 the facilitators to implementing FIPV prevention activities in Title X-supported clinics, as identified by the state and federal off-site key informants.

In general, views about integrating FIPV screening and prevention into Title X clinics varied greatly among the interviewees. Most agreed that the nature of care given at family planning clinics has been shifting in recent years from a clinical focus on reproductive health to a more comprehensive public health approach to care. Respondents attributed some of this shift to research indicating that for many patients, the Title X clinic is their only contact with the public health or the medical system. This change in approach to health care delivery was welcomed by most of the interviewees who felt it was a change for the better. However, a few interviewees felt that it distracted clinic staff from the issue of reproductive health – the primary reason most patients visit Title X-supported clinics. Some interviewees reported that Title X clinics are required to cover an increasing number of topics during patient visits, many of which are not related to family planning. One person noted that if they were seeking family planning services, they would find it frustrating to be queried about a number of other issues.

Table 3.1 Findings from Off-Site Key Informant Interviews by Area of Interest

Evaluation Indicators	Findings
Clinic Policies and Protocols	
Comprehensiveness Usability Perceived usefulness Source and date of inception Changes in protocol Barriers to implementing	Many of those interviewed reported that FIPV screening and referral activities at clinics were not comprehensive at this time, although some did report that they were in the process of developing more comprehensive policies. Views varied greatly on the usefulness of mandatory FIPV screening, with some people passionately behind it and others feeling it lay outside the purview of Title X clinics. Time and money were reported as barriers to developing and instituting FIPV prevention policies and protocols.
Routine Screening Procedures for Family and Intimate Partner Violence	
Timing Criteria for screening Description Perceived ease/discomfort of implementing Methods to ensure confidentiality Procedures following reported FIPV	Most of the state and regional directors interviewed reported that FIPV screening was occurring at intake as part of the health history forms. Many of the same people reported that the clinics in their jurisdiction did not have referral or follow-up procedures in place. There was some disagreement as to whether or not all patients should be screened verbally. A few respondents stated that they felt only those at high risk or those showing signs of violent treatment should be verbally screened for FIPV. Many interviewees felt that clinicians are uncomfortable with screening, referrals, and follow-up activities related to FIPV. There was also some concern expressed about clinics' ability to ensure confidentiality in cases of FIPV.
Health Care Provider and Staff Training Programs	
Training provided Eligibility for training Length of training Curriculum Frequency of updates Perceived usefulness by clinicians	Interviewees at the state and regional level were unsure about the amount of training clinicians received as part of their professional training or were receiving as employees of Title X-supported clinics. Although some interviewees knew that either the state or region offered training programs or conferences on FIPV, they were not certain who attended the programs. Some regions/states reported sending media training materials (CD-ROMs, videos, etc.) to clinics because they realized that either travel distance or time limitations prevented clinicians from attending in-person trainings. Other regions/states are utilizing satellite, audio, and interactive online trainings to try to increase access to training, but there was a sense that it was imperative to have face-to-face training. One respondent noted that sending

	aFIPV training team to sites would be the ideal situation. Several interviewees reported that, based upon needs assessment, there was not much demand for FIPV training. Several respondents mentioned offering Continuing Education Units (CEUs) as an effective incentive to encourage participation in FIPV training.
Collaboration with Community Organizations	
Types of organizations Length and type of collaboration Involvement in protocol development and training Frequency of communication Joint activities	Most of those interviewed reported that collaborations with community organizations were beneficial and worthwhile. Overall it was reported that clinics in urban areas were more likely to be involved in successful collaborations. However, clinics in many rural regions have developed successful community collaborations. Opinions on collaborating with law enforcement varied, with some viewing the relationship as useful because police would be available to protect staff and patients from violent partners or family members. Others felt collaboration with law enforcement was something to be avoided because police have an inhibiting effect on a woman's desire to seek help for FIPV. One respondent reported that local political attitudes toward family planning clinics have been a barrier to forming collaborative relationships even about FIPV.

3.1 Barriers to Success

Time and money were the most frequently cited barriers to implementing comprehensive FIPV programs by both state and regional informants. While time and financial restraints were discussed most frequently and in the greatest detail, other barriers mentioned included: (1) clinics' lack of local resources (safe houses, counseling centers, etc.) to respond to FIPV cases; (2) the lack of staff expertise in FIPV, which is related both to money and to the ability to keep social worker/health educators on staff; and (3) competing demands of other health issues on providers' time and clinic resources. These three areas are discussed below but other barriers noted included the absence of appropriate training in FIPV, local politics involving family planning, language barriers between providers and patients, and the inability to protect victims' privacy and confidentiality.

Time and Money

Time was reported to be a barrier limiting the implementation of comprehensive FIPV prevention programs and staff training. Informants felt that clinicians are now being expected to see more patients per day and as a result, have less time to spend with each patient. In addition to having to see more patients per day, informants also reported that clinicians are required to cover more topics with patients than ever before during these visits. Informants felt that this time crunch may lead to the omission of verbal screening altogether and possibly to a situation where clinicians are sometimes hesitant to verbally screen a suspect case if they do not think there is sufficient time to thoroughly discuss the issue with the patient. These time constraints were reported to force health care workers to prioritize issues with patients, and many informants noted that family planning, sexually transmitted infections (STIs), human immunodeficiency virus (HIV), obesity, and osteoporosis usually outrank FIPV on the list. Likewise, informants stated that many clinics have such busy schedules that they cannot send employees offsite for training. Time was also cited by some informants as a limiting factor in the clinic's capacity to develop community collaborations.

Many informants we talked to felt that Title X budgets are such that there is just enough funding to cover the expense of providing family planning services. Some informants expressed concern that incorporating issues such as adoption and FIPV prevention into the services offered reduced the funds available for providing basic family planning services. Off-site training was not viewed

as an option for many clinics as they cannot afford to pay for staff travel or for substitute health care providers to keep the clinic running while the clinicians attend training. Lack of funding prevents most clinics from hiring social workers and mental health workers and was also seen by many informants as a barrier to developing and maintaining a high-quality FIPV prevention program.

Lack of Safe Houses and Other Community Resources

Another challenge that many informants reported was the fact that in many rural and remote areas, providers do not have a safe house available for patient referral and, when one exists, the location is often known by community members. Interviewees reported that this creates a stressful situation for the clinician screening the patient. As one informant said, *". . . if we know about it [FIPV] and we have nowhere to refer them to, what do we do?"* Some of the clinics will refer the patient to a safe house in another town, but this creates additional challenges, such as how to transport a patient to the safe house in another community and how to protect a patient until she reaches the safe house. Added to these challenges is the question of how much responsibility clinics have in arranging transportation and interim protection for patients who must be relocated to a safe house in another community.

Lack of FIPV Expertise

Another theme that emerged among state and regional informants was the belief that FIPV is often beyond the expertise of many of the clinicians. Interviewees reported that inadequately trained staff often feel uncomfortable with the subject, and therefore can be reluctant to talk to patients about FIPV, even in suspect cases. More than one interviewee compared screening for FIPV to opening Pandora's Box, in that by screening for FIPV, providers must be able to deal with the referral, follow-up, safety, and legal issues that arise when FIPV is identified. Many of those interviewed expressed hope that this could be corrected through provision of additional time and money for staff training. Some informants felt that the lack of staff expertise in FIPV was also related to present salary levels and staff turnover.

Competing Demands

Many of those we interviewed stated that Title X clinics are required to cover an increasing number of topics with patients and, at some point, priorities in these topics will need to be established. For example, many informants reported that there has been a push in recent years to cover topics such as coercive relationships, adoption, HIV, STIs, obesity, and many others. Because time and money are limited, many clinics feel they must make choices in what can be provided to the patient.

3.2 Facilitators for Success

Four facilitators for successful integration of FIPV screening and other prevention activities emerged from the off-site key informant interviews. These are: (1) offering client-centered services; (2) approaching FIPV as part of a comprehensive prevention program that deals with several inter-related issues such as substance use, unintended pregnancies, and violence (including FIPV); (3) increasing awareness about FIPV at the state, regional, and clinic levels by raising it to a higher level of priority than other issues; and (4) having a staff person, such as a social worker, at each clinic to support the clinicians by serving as a FIPV expert.

Client-Centered Services

Some informants reported recommending a client-centered or client-specific approach to cover FIPV and any other areas that need to be addressed. Health care providers offer services they perceive to be most valuable to the patient, based upon the patient's health history form, feedback from the patient, and the provider's perceptions about what the client needs. By prioritizing health care issues, the provider can give the most needed care within the amount of time available to spend with the patient. The key informants who suggest this approach view FIPV as belonging in the category of issues requiring response depending on client needs and believe this approach is effective as long as health care providers have training and experience in FIPV.

Comprehensive Approach to Inter-related Issues

With the growing number of issues Title X-supported clinics are responding to, some clinics are finding it more effective to develop programs that focus on multiple issues that are frequently inter-related. For example, the key informant from one region reported that they have developed a program that targets both violence and substance abuse (alcohol, tobacco, and drugs). This global approach to addressing issues (including FIPV) not only increases efficiency, but also addresses the issue of many problems coexisting, making it more difficult to address any single component of the problem. This approach was seen to further offer a solution to a problem identified by several off-site key informants and referred to by one as *"too many initiatives and not enough resources."*

Making FIPV a High Priority

The priority assigned to FIPV varied greatly among the represented states and regions, and it appeared that those areas assigning it high priority are having greater success in integrating FIPV prevention into Title X-supported clinic activities. One Regional Program Consultant reported that the region's success in incorporating FIPV screening is partially due to the fact that FIPV is given a high priority by the Region's administration. Interviewees from this region reported that they monitor clinics closely to make sure FIPV screening is occurring, something most other Regional Program Consultants reported doing sporadically or not at all. One state grantee reported that the murder of a State Department of Health family planning employee in the late 1990s by her husband had led the Department to make FIPV a top priority. Since this event, the State Department of Health has (1) adapted workplace FIPV awareness training based upon materials developed by private corporations (e.g., Kodak, Liz Claiborne); (2) started observing domestic violence awareness month in October; (3) held luncheon awareness/training programs; (4) formed a domestic violence group that works with the state employees' Human Resource department; (5) participated in awareness raising events; and (6) developed formal policies regarding FIPV. The State Department of Health has also worked on a national standards campaign to develop an FIPV protocol for health care workers and provide training opportunities for clinics in FIPV prevention. While it is unfortunate that a tragedy set these events in motion, this case nevertheless provides an example of the impact possible when FIPV becomes a priority within an agency.

Staff with FIPV Expertise

All of those interviewed agreed that effective FIPV screening requires staff and clinicians who are trained to effectively help patients who may be in a violent situation. Interviewees from states and regions with more comprehensive FIPV screening programs frequently attributed their success to the fact that their clinics have social workers, health educators, and/or mental health workers. They all agreed that having these experts at the clinic played a critical role in establishing an effective FIPV screening program. Many of the state and regional interviewees stated that it would be the ideal case if each clinic had a full-time equivalent (FTE) social worker onsite to whom clinicians could refer identified cases. Social workers were particularly desired by the interviewees because they felt that in general clinicians lack the time and expertise to help a patient that discloses FIPV. Most interviewees considered this a 'wish-list' item only, since lack of funding and patient demand, especially in rural areas, would make it difficult to justify the expense of the position. However, one interviewee suggested that Title X-supported clinics may be able to incorporate this resource by seeking MSW interns.

Appendices

A. Letter from Battelle to State Grantees

Dear [name of SLG]:

Battelle Centers for Public Health Research and Evaluation has been asked by the Office of Population Affairs (OPA) to conduct an in-depth study of family and intimate partner violence (FIPV) prevention activities in Title X clinics. The goal of this project is to document promising practices for clinics regarding FIPV prevention. This study involves interviews with staff members at nine clinics that provide family planning services as well as interviews with off-site key informants who are associated with these clinics. We are writing to request your participation in this study as a key informant familiar with the violence prevention activities conducted by the Title X clinics in your state. A letter from OPA explaining the study and requesting your participation is enclosed.

Involvement in the study requires your willingness to participate in a telephone interview. Two staff members from Battelle will conduct the interview with you sometime in the next 4-6 weeks. The phone call will take about an hour and will be scheduled at your convenience. During the interview, we would like to discuss your background in FIPV, current FIPV-related practices and challenges within your state, FIPV-related training initiatives, collaborations with community organizations regarding FIPV, and specific resources that are being used or are needed in order to further develop your FIPV prevention activities. The information you provide will help us to document the promising practices. We will not cite your name nor attribute quotes in any final reports or presentations. You may refuse to be interviewed or may refuse to answer any questions during the interview without concern. The next page of this letter explains the study and provides contact information should you have questions about your participation.

Although we understand that you already have many responsibilities, OPA and Battelle sincerely hope that you will agree to be part of this study. In the next week or so, we will call you to talk about the study, answer your questions and if you agree, schedule a convenient time for the interview.

If you have any questions about the study in the interim, please call me at 703-875-2110 or email me at powersa@battelle.org. Thank you very much in advance for your participation.

Regards,

Anne Powers, Ph.D.
Project Director

B. Letter from Battelle to Regional Program Consultants

Dear Regional Program Consultant:

Battelle Centers for Public Health Research and Evaluation has been asked by the Office of Population Affairs (OPA) to conduct an in-depth study of family and intimate partner violence (FIPV) prevention activities in Title X clinics. The purpose of this study is to develop promising practices and guidelines that will be useful for all clinics providing family planning services. This study involves interviews with staff members at nine clinics that provide family planning services as well as interviews with off-site key informants who are associated with these clinics. We are writing to request your participation in this study as a key informant familiar with the violence prevention activities conducted by the Title X clinics in your region.

Involvement in the study requires your willingness to participate in a telephone interview. Two staff members from Battelle will conduct the interview with you sometime within the next 4-6 weeks. The phone call will take about an hour and will be scheduled at your convenience. During the interview, we would like to discuss your background in FIPV, current FIPV-related practices and challenges within your region, FIPV-related training initiatives, collaborations with community organizations with your region, and specific resources that are being used or are needed in order to further develop your FIPV prevention activities. The information you provide will help us to develop the promising practices and guidelines. We will not cite your name nor attribute quotes in any final reports or presentations. You may refuse to be interviewed or may refuse to answer any questions during the interview without concern. The next page of this letter explains the study and provides contact information should you have questions about your participation.

Although we understand that you already have many responsibilities, OPA and Battelle sincerely hope that you will agree to be part of this study. In the next week or so, we will call you to talk about the study, answer your questions and if you agree, schedule a convenient time for the interview.

If you have any questions about the study in the interim, please call me at 703-875-2110 or email me at powersa@battelle.org. Thank you very much in advance for your participation.

Regards,

Anne Powers, Ph.D.
Project Director

C. Interview Information and Informed Consent

The Office of Population Affairs (OPA) has asked Battelle Centers for Public Health Research and Evaluation to conduct an in-depth study of family and intimate partner violence prevention activities (FIPV) to identify promising practices in FIPV prevention for use by all clinics that provide family planning services. To gain perspective about FIPV prevention from the DHHS regional level, we are requesting your participation in the study. It will require about an hour of your time to participate in a telephone interview with our researchers.

We are asking for your participation in this interview because you can provide substantial information about your region's operations and characteristics regarding FIPV prevention. Your participation is entirely voluntary. Any information you provide will remain confidential and no one will be able to link you with your responses. Your name, title or region will not appear in any reports or documents. You do not have to answer any question that you choose not to and if at any time during this interview you want to stop, please say so and we will conclude the interview.

The interview will be audio taped; names and other identifying information will not be included in any transcriptions or reports. Battelle will destroy identifying information and will permanently erase all tapes upon completion of the analysis.

If you have any questions or concerns about this study, please contact Anne Powers, Project Leader at 703-875-2110.

If you have any questions about your rights as a research participant, please contact Dr. Margaret Pennybacker, Chair of the IRB at 1-877-810-9530, ext 500. Please keep this form for your records.

By agreeing to the interview, I certify that I have read this consent form, and agree to participate in this research study.

D. Interview Guide for Off-site Key Informants

Questions will be asked as appropriate for the individual being interviewed.

Opening:

Tell me about your work in FIPV.

- How long? Research/clinical/advocacy?
- Academic training
- Career trajectory
- What led to interest in FIPV

FIPV Activities in Title X Clinics:

What do you see as role of Title X Family Planning clinics in FIPV control?

In Title X clinics, how much of a priority are FIPV activities?

- Other activities that are priorities
- Factors that contribute to priority of FIPV (high or low)

If you could imagine a model FIPV program for family planning clinics, what elements would it include?

- Screening
- Documentation
- Training
- Referrals/services/community resources
- Follow up

Is there an extant model/protocol/guideline that you consider to be ideal?

How does the current state of FIPV services in Title X Family Planning clinic compare with the ideal model?

What factors contribute to the differences between the ideal program and current practices?

What are some of the challenges that clinics experience in providing FIPV screening and referrals in Title X clinics? How can we best meet these challenges?

How can these be addressed to improve FIPV services?

Are there any clinics that you know of using this model? Can you tell me about their experience in using the model?

Training:

How well do you think the professional schools (medical, nursing etc) prepare practitioners to deal with the problem of FIPV?

What is your overall assessment of FIPV training opportunities for Title X clinic staff?

What do you think are the best training programs, either in schools or as professional training?

Are there specific training programs or opportunities that you wish were more available? Are they readily available and how?

How do you think that training impacts practice? (Benefits, drawbacks)

If you could design a model FIPV training program, what components would it have?

- Format (web, hard copy, video, classroom, role-playing)
- Subject matter
- Certifications

Resources:

What additional materials or resources would be of the most benefit to clinics? Patient oriented? Staff oriented?

What is the best format for these materials? Web? Hard copy?

What other prevention activities would you undertake if resources were not an issue?

Collaboration with Community Organizations:

How do community/advocacy groups complement the FIPV services of family planning clinics?

What advantages and disadvantages do they pose?

Are there barriers to working with community/advocacy groups? How could they be overcome?

How does the legal system (police, prosecutors, etc) interface with medical and social services? Benefits? Problems? Barriers? How could this interface be improved?

Are there any specific agencies or organizations that you'd like to work with to improve FIPV activities? What barriers do you foresee to establishing this relationship?

Closing

Is there anything else you'd like to tell me about FIPV screening or services in Title X clinics? Thank you for your insights. We appreciate the time and thoughts that you've shared with us.

Evaluation Report

Family and Intimate Partner Violence Resource Guide
For Integrating Services into Family Planning Clinics

For the Project:

A *Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Selected Title X-supported Family Planning Clinics*
Contract Number 282-98-0019
Task Order 13

Submitted to:

Pankaja Panda, PhD, MPH
Office of Population Affairs
US Department of Health and Human Services
1101 Wootton Parkway, Suite 700
Rockville, MD 20852

September 27, 2005

by

Anne Powers, Ph.D.
Holly Carmichael

Battelle
The Business *of* Innovation
Centers for Public Health Research and Evaluation
2101 Wilson Blvd., Suite 800
Arlington, VA 22201

Table of Contents

1.0 Introduction

Battelle Centers for Public Health Research and Evaluation is pleased to provide this report to the Office of Population Affairs (OPA) under contract no. 282-98-0019, Task Order 13, *A Collaborative Evaluation of Family and Intimate Partner Violence Prevention Activities in Title X-supported Family Planning Clinics.* This report documents the results of an evaluation of the *Family and Intimate Partner Violence Resource Guide for Integrating Services into Family Planning Clinics* developed by JSI/Denver. This evaluation focused on the content and format of the Resource Guide, as well as the clarity and breadth of the information provided within it.

Three methods were used to evaluate the Resource Guide. First, telephone interviews were conducted with state grantees who had served as off-site key informants for another part of this project. Second, telephone interviews were conducted with the health care providers who had also served as key informants for another part of this project and who are employed by the clinics where the Battelle research team conducted site visits. Finally, the opinion of Ms. Elaine Arkin, a communications specialist with expertise in FIPV, was solicited. Ms. Arkin reviewed the Resource Guide and offered her expert opinion in a report to Battelle's Project Director. Her report is summarized here.

The Resource Guide was developed to assist family planning clinic staff in accessing materials that can support the development of multi-faceted FIPV prevention programs including staff training and education, clinic protocols and policies, screening and response procedures, clinic environment and maintenance of referral networks. All parts of a FIPV prevention program are intended to address the needs of Title X-supported clinic clients relative to FIPV. Based on this understanding of the purpose of the Resource Guide, three questions were developed to guide the evaluation. These include:

- Did the resource kit meet its intended objectives?
- Did the target audience find it useful, clear and complete?
- Is the information current and accurate?

Following this introductory section, we present the methods used for data and analysis for this evaluation (Section 2.0), followed by the key findings derived from the data analysis in Section 3.0. Finally, recommendations and conclusions are presented in Section 4.0. Based upon information gathered from the interviewees and our communications consultant, the final section includes recommendations regarding the use and dissemination of the Resource Guide as well as suggestions for improvement that can be implemented in future iterations of the Guide.

Appendices to this report include recruitment letters (Appendices A and B), interview information and informed consent (Appendix C) and interview instruments (Appendix D and E).

2.0 Methods and Analysis

Telephone interviews were conducted with two types of individuals – state Title X grantees and clinic directors – as part of the Resource Guide evaluation. Nine state Title X grantees were invited to participate in the evaluation of the Resource Guide because they had participated in an earlier phase of the study and members of Battelle's research team had visited a clinic in their state. Each state was located in one of the ten DHHS regions with the exception of Region VIII. In addition to state Title X grantees, the clinic director or one clinician from each of the nine clinics visited earlier in this study were invited to evaluate the Resource Guide.

In total, 6 state Title X grantees and 2 clinicians were interviewed about the Guide. The number of interviewees was lower than expected because recruitment for this phase of the study proved to be difficult and, in consultation with OPA, the research team elected to limit the number of interviews in the interest of time. Of the 9 state Title X grantees asked to participate, 3 could not be reached by telephone within the study's time frame. Of the 9 clinic directors or clinicians asked to participate, 2 could not be reached by telephone and 4 were from clinics that did not receive the Resource Guide within the study's time frame. One of these clinics was also no longer receiving Title X funding and would not have received the guide in any case. Finally, one clinic director had left the position recently and we could not identify another point of contact within the study's time frame.

Appendices A and B include the invitation letters sent to the state grantees and clinic staff inviting them to participate in the study and explaining the topics that would be covered during the interview. Appendix C was sent along with the invitation letter and explains the key informants' rights as research participants. One to two weeks after these letters were sent, a member of the Battelle research team followed-up with a telephone call to answer questions and schedule the interviews.

All interviews were completed in May and June of 2005 by one member of the research team using the interview guides attached in Appendix D and E. Interviews lasted approximately 20 minutes and were tape recorded and later transcribed for analysis and summary.

3.0 Findings

State Grantee Summary

The following section reports the responses of the state grantees regarding the completeness and clarity of the FIPV Resource Guide. First, grantees' expectations of how the Guide will most likely be used are discussed, followed by the topics within the Guide that grantees found most useful. Gaps and limitations are discussed next and the state grantee summary concludes with their recommendations for possible future iterations.

Utilization Expectations. The state grantees felt that the information provided within the Guide would be beneficial to clinicians, but most noted that it was geared more towards individuals at the state level than at the clinic level. State grantees thought that it was a tool the state agency could use to develop policies and then filter these procedures and tools down to the clinics. Of the clinic staff expected to use the Guide, the state-level grantees saw it as being geared towards the clinicians, nurses, and administrators. One grantee suggested that individuals in charge of quality control at the clinics would benefit from the resources provided in the Guide. The interviewees would like to see all parts of the Guide used, but believe that only some (particularly the policies and protocols) will be used regularly. Most interviewees noted that manuals typically end up unused, sitting on a storage shelf and expressed concern that this would happen to the FIPV Resource Guide.

Two of the grantees mentioned the idea of collaborating with local organizations, such as their local coalition against domestic violence, to produce an alternate version of this Resource Guide that would be specific to their state. One grantee also mentioned that the Resource Guide may be presented as a training tool at their annual providers' meeting. Most of the grantees said that clinics were already using different sections of the manual in staff training as orientation to FIPV. They expressed appreciation for the other resources that are provided in the training section. One grantee, for instance, said *"The clinics have appreciated the manual and have used it as a training tool, which is how we presented it when we delivered it. They have used it as a back-up reference tool as well, but that is not the main use. This is not something I would give to an educator; it would be more of a masters-level or clinician level person who was developing training or protocols."* One clinic has already used the guide to train nursing students at a nearby college to provide an overview of FIPV and assessment techniques.

Useful Features. The state grantees interviewed agreed that the Resource Guide provided the resources and information that were expected and needed to develop FIPV prevention activities and programs. The policies, protocols and screening tools found in the Guide were overwhelmingly viewed as the most helpful tools in the Guide. For example, one grantee said *"The sample clinic protocols were excellent, so I think agencies will use those. I thought that the domestic violence screening documentation form was very good and very specific and could be used. Those were the pieces that I thought would be used as a clinical tool."* The multitude of tools was also appreciated, as grantees felt that individuals could use the best of each policy and/or tool and modify it to fit their specific needs. One grantee also felt that, even if the department did not use the policies and protocols that were included as examples, the inclusion

of these tools might stimulate conversation and persuade the department to develop its own resources.

The domestic violence background information and the definitions of abuse were also mentioned as helpful and well organized, as were the expected responses to answers affirming FIPV. As one grantee put it, *"all of our clinics ask the question – it's just responding to the answer that they have trouble with."* There were also a number of grantees that appreciated the mandatory reporting section, as they found that many employees at their clinics are confused about the reporting requirements.

The majority of the respondents said that they would recommend this Resource Guide to colleagues, but only as a secondary source of information. They viewed it as a great reference tool, but because of its focus on developing intense programs, felt it should only be used as a supplement to tools that are already in use.

Gaps and Limitations. Though the interviewees found the content to be relatively comprehensive, they each stated their concern regarding duplicative material. Another issue with the guide was that it was not user-friendly and could not be expected to be used by the busy clinic staff who need something much more targeted and specific. While interviewees stated that they were able to find the information that they were looking for within a reasonable amount of time, they often noted that the layout was not precise and therefore the compilers/authors had to repeat information already discussed. This repetition of information detracted from the organization of the Guide. They also felt that because the Guide is so voluminous, some content may be overlooked.

The index was seen as helpful, although one grantee suggested the addition of page numbers throughout the Resource Guide. One grantee also requested that the publication dates of the references be listed on the publication, rather than requiring a user to flip through the appendix to find this information. This would give the user confidence that the material was current. Although most state grantees said that their clinics already had more advanced policies in place than those detailed in the Resource Guide, they were impressed with those that were included. However, they found the information within these policies and protocols to be too dense and mentioned that in the past they have had better luck with flowcharts and checklists. Grantees also requested that the authors clearly state whether or not users had permission to modify the forms that were included.

Suggestions for Future Iterations. While the grantees were impressed with the work that was done to compile the Resource Guide, they did offer some suggestions for improvement in future iterations. Recommendations include:

- Include more recent and well known references such as the U.S. Preventive Services Task Force's recommendation statement regarding FIPV screening; resources produced by the National Coalition Against Domestic Violence and resources produced by the American College of Obstetrics and Gynecology (ACOG) regarding violence against women
- Include screening practices for special populations (e.g., adolescents, immigrant women)

- Add information on barriers to effective responses to FIPV
- Focus on resources that were developed specifically by family planning organizations
- Include implementation practices of suggested policies
- Develop and include a condensed version of the binder in booklet form for clinicians
- Note whether the tools included have been tested or validated and whether clinicians or academics developed them
- Include a website of the information so that it is more easily updateable. This allows users to print off most recent versions of materials.

Clinician Summary

The following section presents the views of the interviewed clinicians regarding the completeness and clarity of the FIPV Resource Guide. Utilization expectations, useful features, gaps and limitations and suggestions for future iterations are included. Note that this information represents the views of two individuals, both of whom are quite knowledgeable about FIPV.

Utilization Expectations. The clinicians interviewed believed that the information included in the Resource Guide would be helpful to anyone being introduced to FIPV or learning to assess FIPV. They noted that the general information could assist their front office staff, while the core of the materials would be used by their providers such as nurses, social workers and physicians' assistants. However, because the clinics represented already have policies, protocols and resources in place, they believe that this Resource Guide will be used as more of a supplement to their current processes rather than a primary source of information. They also thought that it could be used as educational material for a group training session for their staff.

Useful Features. The clinicians agreed with many of the comments that the state grantees made regarding the FIPV Resource Guide. Each felt that the Guide provided the majority of the information that they expected. Contrary to the opinions of the state grantees, the clinicians seemed to find the content and format to be concise and straightforward. One clinician explained, *"The Guide seems to be formatted specifically for nurses and doctors."* They said that, although they had to hunt for the information they were looking for, it did not take too much effort to do so. They found the highlighted text helpful, as it allowed them to scan through the material and pick out the most important information, yet provided detailed information for them to sort through when they had time to do so. They also found the "how to ask" section very helpful and appreciated the "how to follow up" response section. One clinician also appreciated the "myths of abuse" section and the statistics about abuse. She believed that information would help all staff involved in the process of identifying abuse. She also appreciated the Emergency Room tricks (such as the blue stickers used as markers) that were detailed within the Guide. The clinicians interviewed also expressed appreciation for the section on reporting. They each said that they would direct colleagues to this Guide, but only as a tool to supplement current processes.

Gaps and Limitations. The clinicians that were interviewed had very few complaints about the Resource Guide. One clinician noted that some of the internet links for resources were difficult

to use or incorrect. She felt that if they were to be included, they should be accurate and easy to use. Another clinician suggested that naming the section labels, rather than using a number scheme, would have made attaining the information less complicated for users. The FIPV referral sheet was mentioned as being vague; the clinician that touched upon this issue was not sure how to use it and requested that instructions be included.

Suggestions for Future Iterations. While the clinicians were impressed with the work that was done to compile the Resource Guide, they did offer some suggestions for improvement to future iterations. Recommendations include:

- Include screening practices and background information pertaining to domestic violence as it relates to special populations
- Add downloading instructions for protocols
- Develop and include quick-reference cards explaining the myths/statistics/signs of abuse
- Include the backgrounds of the authors of included policies and protocols. Also provide more information about the development and validation of these tools.

Specialists' Review

The following section summarizes the review conducted by our communication specialist regarding the completeness and clarity of the FIPV Resource Guide. Ms. Arkin's recommendations regarding content are followed by her recommendations regarding format and the CD-ROM that accompanies the Resource Guide.

Content Recommendations. Overall, Ms. Arkin found the Resource Guide to be a rich resource for clinic management staff and suggested minor changes to make it even more useful to clinic management staff.

Ms. Arkin found the content within the Resource Guide to be comprehensive, but noted that using the Guide will require some motivated searching by busy clinic staff. In order to motivate the user to take the time to search through the materials and then use them, Ms. Arkin made the following suggestions:

- Add additional brief information to the *Introduction* to quickly orient the user to the issue and the toolkit and what they should do with it. Information should include:
  - A brief definition of FIPV and who is likely to be affected
  - A statement of why it is important for the clinic to be prepared to manage this issue
  - A checklist of tasks that the clinic should perform. An example of this checklist is "Seven Steps" a clinic can take to respond to the need to address FIPV:
    1. Provide a welcoming and safe environment, including educational materials for clients
    2. Assess needs for staff education
    3. Provide appropriate staff education/training
    4. Tailor a policy and protocol to fit your clinic

5. Provide staff with screening and assessment forms
6. Provide staff with a current referral list
7. Annually reassess your clinic's capacity to help women who may be exposed to violence.

- Following the checklist, explain that all of the resources and tools are included to make it easy for the user to take each of these steps and orient them to the appropriate sections of the Guide. It would also be helpful to let clinic staff know if permission has been granted by the creator/author to alter the materials.

- Explain the "safe and welcoming environment" that is referenced in the introduction. Provide examples of what this might entail.

Although the majority of this information is already in the Resource Guide, the organization made it difficult to find and therefore Ms. Arkin suggests that the Guide might be difficult to use in the clinic. Including this information in the *Introduction* will provide clinicians and other clinic staff with an easy reference tool.

Following the *Introduction*, Ms. Arkin recommended that a descriptive sentence be added to the top of each page that begins a new section. This statement should include instructions on using the information provided within the section. An example of such a statement is: "this section describes how to assess clinic needs, and how to use the assessment tools provided to determine staff needs for education." This information should refer back to the checklist in the *Introduction* and should indicate which, if any, supplementary materials provided in the section can be copied, how the materials can be used, and with whom they can be shared. She found the current introductory pages that are included in the sections very helpful and recommended that they remain but suggested they be more descriptive. Adding the more active "steps to take" on the first page of each section would prompt the user to read the information provided with context about what to do with it.

Format Recommendations. Ms. Arkin recommended a number of changes to the format of the Resource Guide. For example, it would be helpful to users to include a page that thanks and credits to all the sources of the information that are in the Guide. This page should indicate whether or not the source provided permission to reprint and distribute the material found within. If permission has been granted, Ms. Arkin recommended that the tools be edited appropriately and made ready-to-use.

Regarding the publications that are included in the Guide as resources, Ms. Arkin recommended that a disclaimer be included on the introductory page at the front of each section. This disclaimer should state that articles have been reproduced and some may contain referral or source information that is not current. However, she also suggested that the authors reconsider some of the older materials and explain the criteria used for including articles, and that all were vetted and applicable as of 2005. This, and adding the source of the publications, will increase credibility.

Recommendations Regarding the CD-ROM. Regarding the accompanying CD-ROM, Ms. Arkin suggested that the CD ROM could be a more interactive tool by allowing users to (1) link to the web sites referenced, and (2) tailor and use the sample forms provided. Ms Arkin acknowledged

that permission may need to be obtained from the form owners to allow others to tailor and use them (e.g., remove "Mercy Hospital" and add one's clinic name). However, in some cases the included materials were developed specifically for this kit, such as the Referral List in Section 5, so this may not be an issue. She also suggested the development of forms in a Word template, rather than an Acrobat file, so that users may electronically enter data on the form.

4.0 Recommendations and Conclusions

The reviewers of the Resource Guide generally found that the content that is needed and expected of a resource of this type is contained within the Resource Guide. The state grantee and clinician reviewers saw the Resource Guide more as a management or training tool, rather than a clinical resource, owing primarily to its size and style of organization. Reviewers suggested that the Resource Guide will be most effective if used as a group training guide, and delivering it to the clinics as a formal training tool will enable clinicians to build upon their current knowledge of FIPV, yet not overwhelm them with material that they do not have time to utilize. There was also a trend among the reviewers to suggest that some reorganization of the content and more orientation about each section for the intended user would make the Guide more user-friendly. The reviewers also noted that some of the materials were older than they expected and would soon require updating.

Based on the input from the three sources, we have developed the following recommendations for modifications to future iterations of this toolkit.

- Given that the Resource Guide was developed primarily for Title X-supported Clinics, more materials geared directly towards family planning organizations would be helpful. One reviewer suggested ACOG as a source for this type of information.
- An additional chapter on screening techniques for special populations would be helpful. While clinicians do not deal with these populations on a day-to-day basis, it is important to call attention to these significant differentiations. This would include adolescents and immigrant women.
- Include an enhanced version of the CD-Rom that would allow users to adjust the forms and templates as needed and use links to access the resources via the internet.
- Update the resources and research with each new iteration of the Resource Guide and include the source, author and date of publication of each document. Reviewers wanted to be able to assess the credibility of the information source.
- Make it clear to the users that they can use and modify the forms and templates included, and as noted above, include modifiable versions in the CD-ROM.
- Include more orientation for the reader of the content of the Resource Guide in the introduction. In addition, each chapter would benefit from a similar orientation to the content.

Finally, state grantees noted that they experienced some confusion about how to disseminate the Resource Guide and to whom. When interviewed, a few were unclear about whether they had done it properly. In the future, it may be helpful to include additional dissemination instructions for state grantees.

Appendix A – State Grantee Recruitment Letter

[Address]

Dear [Name]:

Battelle Centers for Public Health Research and Evaluation has been asked by the Office of Population Affairs (OPA) to conduct an in-depth study of family and intimate partner violence (FIPV) prevention activities in Title X clinics. The goal of this project is to document promising practices for clinics regarding FIPV prevention. Last year, you took part in this study by consenting to a telephone interview with Jennifer Boyle about violence prevention activities conducted by the Title X clinics in your state. We are writing to ask for your participation once again. It will be a telephone interview as well and will only take about 20 minutes of your time. We will ask you a few questions to solicit your opinions about an FIPV prevention resource guide that you recently received from OPA or their contractor, JSI (John Snow Inc).

Your involvement in the study requires your willingness to answer about 10 questions in a telephone interview. I would like to conduct the interview with you sometime in the next few weeks. The phone call will be short and scheduled at your convenience. Prior to the interview, we ask that you review the resource guide. During the interview, we will ask how you think the guide will be used at the state and at the clinic level, what materials are most and least useful, what material is missing from the guide that you would like to have, as well as a few questions about the formatting of the guide.

The information you provide will help us to evaluate the resource guide. We will not cite your name nor attribute quotes in any final reports or presentations. You may refuse to be interviewed or may refuse to answer any questions during the interview without concern. The next page of this letter explains the study and provides contact information should you have questions about your participation.

Although we understand that you already have many responsibilities, OPA and Battelle sincerely hope that you will agree to be part of this study. In the next week or so, we will call you to talk about the study, answer your questions and if you agree, schedule a convenient time for the interview.

If you have any questions in the interim, please call me at 703-875-2960 or email me at carmichaelh@battelle.org. Thank you very much in advance for your participation.

Regards,

Holly Carmichael
Health Researcher

Anne Powers, Ph.D.
Project Director

Appendix B – Clinic Director Recruitment Letter

[Address]

Dear [Name]:

Battelle Centers for Public Health Research and Evaluation has been asked by the Office of Population Affairs (OPA) to conduct an in-depth study of family and intimate partner violence (FIPV) prevention activities in Title X clinics. The goal of this project is to document promising practices for clinics regarding FIPV prevention. Last year, you took part in this study by participating in a site evaluation and in-person interview with Anne Powers about violence prevention activities conducted by [Clinic]. We are writing to ask for your participation once again. It will be a telephone interview and will only take about 20 minutes of your time. We will ask you a few questions to solicit your opinions about an FIPV prevention resource guide that you recently received from your State Grantee, OPA or OPA's contractor, JSI (John Snow Inc).

Your involvement in the study requires your willingness to answer about 10 questions in a telephone interview. I would like to conduct the interview with you sometime in the next few weeks. The phone call will be short and scheduled at your convenience. Prior to the interview, we ask that you review the resource guide. During the interview, we will ask how you think the guide will be used in your clinic, what materials are most and least useful, what material is missing from the guide that you would like to have, as well as a few questions about the formatting of the guide.

The information you provide will help us to evaluate the resource guide. We will not cite your name nor attribute quotes in any final reports or presentations. You may refuse to be interviewed or may refuse to answer any questions during the interview without concern. The next page of this letter explains the study and provides contact information should you have questions about your participation.

Although we understand that you already have many responsibilities, OPA and Battelle sincerely hope that you will agree to be part of this study. In the next week or so, we will call you to talk about the study, answer your questions and if you agree, schedule a convenient time for the interview.

If you have any questions in the interim, please call me at 703-875-2960 or email me at carmichaelh@battelle.org. Thank you very much in advance for your participation.

Regards,

Holly Carmichael
Health Researcher

Anne Powers, Ph.D.
Project Director

Appendix C – Interview Information and Consent

The Office of Population Affairs (OPA) has asked Battelle Centers for Public Health Research and Evaluation to conduct an in-depth study of family and intimate partner violence prevention activities (FIPV) in clinics that provide family planning services. The goal of the study is to document promising practices in FIPV prevention for these clinics. An additional part of this study, which will contribute to the promising practices, is an evaluation of an FIPV prevention resource guide. You should have received one of these guides earlier this year. To evaluate the resource guide and gain a better understanding of how it will be used in Title X clinics, we are requesting your participation in a telephone interview to provide feedback on the resource guide. The telephone interview will take about 20 minutes of your time.

Your participation is entirely voluntary. Any information you provide will remain confidential and no one will be able to link you with your responses. Your name, title or state will not appear in any reports or documents. You do not have to answer any question that you choose not to and if at any time during this interview you want to stop, please say so and we will conclude the interview.

The interview will be audio taped; names and other identifying information will not be included in any transcriptions or reports. Battelle will destroy identifying information and will permanently erase all tapes upon completion of the analysis.

If you have any questions or concerns about this study, please contact Anne Powers, Project Leader at 703-875-2110.

If you have any questions about your rights as a research participant, please contact Dr. Margaret Pennybacker, Chair of the IRB at 1-877-810-9530, ext 500. Please keep this form for your records.

By agreeing to be interviewed, I certify that I have read this consent form, and agree to participate in this research study.

Appendix D – State Grantee Interview Guide

We have been tasked by the Office of Population Affairs to conduct an evaluation of the content and format of the "FIPV Resource Guide for Integrating Services Into Family Planning Clinics" that was developed by JSI Research & Training Institute. Your insight is instrumental in assessing the effectiveness of this tool. This interview should only take approximately 20 minutes of your time.

Opening:

1. Have you had the chance to review the FIPV Resource Guide?

    a. *If Yes, proceed with interview*
    b. *If No, request that the interviewee reviews the Resource Guide and schedule a time to call back and conduct the interview.*

2. Does this Resource Guide provide all of the resources and information you believe are needed in regard to FIPV prevention activities?

3. Was there information that you were hoping to find that you were unable to?

4. Do you think that you or your clinics will use this Guide regularly? Why/why not? How?
    a. Who is most likely to use the Guide (State-Level Interviewee or Individual Clinics)
        i. *If individual Clinics, Who within the clinic is most apt to use the Guide?*

5. Is the format of the Guide useful to [the user]? What is the best format for [the user]?

6. Is the presentation of the material clear and usefully organized?

7. Is the level of information included appropriate for [the user's] use?

8. Were there particular sections that you think are incredibly useful? Were there particular sections that you think are useless?

9. Would you recommend the Guide to a colleague?

10. Has [Specific Clinic] received a copy of this Resource Guide?
    a. *If yes, May we contact them to discuss their impressions?*
    b. *If no, Why not? Will they?*

11. Do you have any suggestions for improvement to the Resource Guide?

Closing:
Thank you very much for your time. Are there any other comments you'd like to make before we end the interview?

Appendix E – Clinic Director Interview Guide

We have been tasked by the Office of Population Affairs to conduct an evaluation of the content and format of the "FIPV Resource Guide for Integrating Services Into Family Planning Clinics" that was developed by JSI Research & Training Institute. Your insight is instrumental in assessing the effectiveness of this tool. This interview should only take approximately 20 minutes of your time.

Opening:

1. Have you had the chance to review the FIPV Resource Guide?

    a. *If Yes, proceed with interview*
    b. *If No, request that the interviewee reviews the Resource Guide and schedule a time to call back and conduct the interview.*

2. Does this kit provide all of the resources and information you need in regard to FIPV prevention activities?

3. Was there information that you were hoping to find that you were unable to?

4. Do you think that your clinic will use this toolkit regularly? Why/why not? How?

    a. Who, within your clinic, is most likely to use the kit?

5. Is the format of the kit useful to you? What is the best format for you?

6. Is the presentation of the material clear and usefully organized?

7. Is the level of information included appropriate for your use?

8. Were there particular sections that you found incredibly useful? Were there particular sections that you found useless?

9. Would you recommend the kit to a colleague?

10. Do you have any suggestions for improvement to the Toolkit?

Closing:
Thank you very much for your time. Are there any other comments you'd like to make before we end the interview?

Engel-Cox, Jill A

From: Chidester, Richard J
Sent: Sunday, November 06, 2005 8:37 PM
To: Engel-Cox, Jill A
Subject: FW: Gulf Study Initial Findings Report presentation, November 10,Washington

Jill, is this something that would interest you?

Richard J Chidester

Vice President
Battelle Memorial Institute
723 Main Street, Suite 650
Houston, Texas 77002

Phone: 713-222-2206 x 15
US cell: (832) 659-3818 (please note new number)
Mexican cell: 011-5255-2727-1376

From: Gajewski, Stephen W
Sent: Friday, November 04, 2005 6:33 PM
To: Chidester, Richard J
Subject: RE: Gulf Study Initial Findings Report presentation, November 10,Washington

yes. Jill Engel Cox would be best if available. I can supply coverage for this modest activity. (oops, she is one of yours - can you?)

From: Chidester, Richard J
Sent: Friday, November 04, 2005 1:00 PM
To: Gajewski, Stephen W
Subject: FW: Gulf Study Initial Findings Report presentation, November 10,Washington

Should we ask someone from the D.C. office to participate? They will probably want a charge number. Let's discuss.

Richard J Chidester

Vice President
Battelle Memorial Institute
723 Main Street, Suite 650
Houston, Texas 77002

Phone: 713-222-2206 x 15

into account inherent disaster risks in the Gulf, and thus ensuring that jobs and livelihoods are regained and expanded. On the Mexican side of the Gulf, there is a clear message here that making gains within the sixth largest economy in the world will help Mexico to become more competitive in the global economy.

A copy of the Study's initial findings report can be downloaded at:

http://s48.yousendit.com/d.aspx?id=2AS3Z6OJSEIXV025GD4IWC2BVV

For security reasons, please let me know as soon as possible if you are able to attend this luncheon presentation. If you are unable to attend, but would like to send a Washington representative of your firm, please confirm their attendance by return email.

I look forward to seeing you in Washington on November 10. Many thanks and kind regards. Gary

Gary L. Springer
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The *Gulf of Mexico States Partnership, Inc.* is a private sector advocacy organization for the Gulf of Mexico border states. The Partnership supports the Gulf of Mexico Congressional Caucus in its mission of education, consensus-building and creation of new regional initiatives in the areas of transportation, homeland security, environment, economic development, education, and international trade in the border states of the Gulf of Mexico basin. The Partnership was formed as the private sector counterpart of the official 11-state member Gulf of Mexico States Accord (GOMSA). The Partnership is a 501-c-6 not-for-profit organization under the US Tax Code. Membership in the Partnership is open to businesses, chambers of commerce and economic development organizations and non-governmental organizations interested in supporting the prosperity of the Gulf of Mexico border region.