



Commentary

Intimate Partner Violence: Perspectives on Universal Screening for Women in VHA Primary Care

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Intimate partner violence (IPV) poses a significant threat to public health and safety, particularly for women, in the United States. IPV can be defined as physical violence, sexual violence, threats of physical or sexual violence, and stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (Black et al., 2011). Epidemiological studies in the general population suggest that one in three women experiences IPV during her lifetime (Black et al., 2011); nearly equivalent rates (33%) of lifetime IPV exposure have been reported among female veterans (Dichter, Cerulli, & Bossarte, 2011; Murdoch & Nichol, 1995). There are currently 1.8 million female veterans in the United States (Department of Veterans Affairs, 2007). Women veterans using Veterans Health Administration (VHA) facilities for their health and mental health care often demonstrate diminished physical and mental health relative to their civilian peers; this difference in health status is attributed, at least in part, to women veterans' greater exposure to trauma (Dobie et al., 2004; Fontana & Rosenheck, 1998; Frayne et al., 2004; Kimmerling, Gima, Smith, Street & Frayne, 2007). IPV exposure may be an underappreciated factor contributing to the relatively poorer physical and mental health outcomes for women veterans (Murdoch & Nichol, 1995).

Recent estimates suggest that 7 million U.S. women are victimized by their intimate partners each year (Black et al., 2011). The medical and mental health sequelae of IPV victimization are manifold. Specifically, more than 1,000 U.S. women die each year as a result of physical assault from husbands or boyfriends (Catalano, 2007). Moreover, the significant medical

sequelae of IPV can include acute soft tissue injuries, fractures, joint dislocation, complications associated with anoxia (i.e., from strangulation), and traumatic brain injury (Corrigan, Wolfe, Mysiw, Jackson, & Bogner, 2003; Sheridan & Nash, 2007). Further, IPV has been associated with chronic health conditions such as musculoskeletal and genitourinary disorders (Bonomi et al., 2009; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Leserman, Li, Drossman, & Hu, 1998). Because IPV commonly includes sexual assault or abuse, risk for sexual health problems, including sexually transmitted infection (including HIV), and unintended pregnancy, is heightened among women with IPV exposure (American College of Obstetricians and Gynecologists, 2012; Bauer et al., 2002; Campbell et al., 2008; Hess et al., 2012; Mittal, Senn, & Carey, 2011; Russell et al., 2009; Senn, Carey, & Vanable, 2010; Seth, Raiford, Robinson, Wingwood, & Diclemente, 2010).

IPV has also been linked to other deleterious mental health consequences including increased rates of suicide attempts, sleep disturbances, problematic substance use, and ineffective coping (Becker, Stuewig, & McCloskey, 2010; Bonomi et al., 2009; Cavanaugh, Messing, Del-Colle, O'Sullivan, & Campbell, 2011; Dichter et al., 2011; Ellsberg et al., 2008; Linton, Larden, & Gillow, 1996; Nicolaidis, Curry, McFarland, & Gerrity, 2004). IPV exposure has also been linked with the development of several mental health conditions including posttraumatic stress disorder (PTSD) and depression (Campbell & Lewandowski, 1997; Coker, Weston, Creson, Justice, & Blakeney, 2005; Pico-Alfonso et al., 2006; Golding, 1999; Nathanson, Shorey, Tirone, & Rhatigan, 2012) that are common among female veterans (Fontana & Rosenheck, 1998).

The significant prevalence of IPV exposure among female veterans coupled with its serious implications for their health and well-being suggests a strong need for the development of

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a standard, universal screening program designed to detect IPV risk among women seeking services within VHA. As the largest integrated health care system in the United States, VHA is a leader in quality and innovation and boasts a fully implemented electronic medical record system. The VHA provides medical and mental health services to approximately 8.6 million veterans each year, 6% (about 500,000) of whom are female (Frayne et al., 2010; Department of Veterans Affairs, 2007). The development of an IPV screening program in VHA may be particularly timely given the rapidly growing and changing demographics of the female veteran population. These changes include increasing rates of pregnancy among younger women veterans (Goyal, Borrero, & Schwartz, 2012; Holt, Grindlay, Taskier, & Grossman, 2011; Yoon, Scott, Phibbs, & Frayne, 2012), which increases risk for IPV exposure (Brownridge et al., 2011; Devries et al., 2010), and increasing concerns about the risk of IPV among service members recently returned from Iraq or Afghanistan (Fraser, 2011; Marshall, Panuzio, & Taft, 2005; Sayers, Farrow, Ross, & Oslin, 2009; Teten, Schumacher, Bailey, & Kent, 2009), particularly those whose male partners have PTSD (Teten et al., 2010).

Successful IPV screening must incorporate mechanisms for appropriate and comprehensive responses to positive screens. This may include coordination of primary care, mental health, social work, and legal services. The VHA has successful models of integrated care and universal screening for other health conditions and exposures. In recognition that primary care visits provide the opportunity to assess for unrecognized disease, VHA already has mechanisms in place to routinely screen for mental health conditions in men and women using well-validated measures such as the Patient Health Questionnaire for depression (Kroenke, Spitzer, & Williams, 2003), the Primary Care-PTSD Screen for PTSD (Prins et al., 2003), and the Alcohol Use Disorders Identification Test for alcohol use disorders (Bradley et al., 2007). The VHA also routinely screens for other trauma exposures, such as military sexual trauma, that may increase risk for subsequent mental health conditions (Kimerling et al., 2007). The VHA's military sexual trauma screening is one of the first comprehensive health policy responses to sexual trauma in the country, and has resulted in a two-fold increase in likelihood of engagement in mental health treatment among veterans who screened positive compared with those who screened negative (Kimerling, Street, Gima, & Smith, 2008). Screening procedures in VHA are also enhanced owing to the use of an electronic medical record system, which has been shown to improve screening quality (Van Cleave et al., 2012). In 2007 and 2008, the VHA underwent major initiatives to foster Primary Care-Mental Health Integration, resulting in improved detection of mental health diagnoses among primary care patients (Zivin et al., 2010), treatment of mental health conditions in the primary care setting, and increased engagement in specialty mental health care (Wray, Szymanski, Kearny, & McCarthy, 2012). The Primary Care-Mental Health Integration initiative has resulted in several programs, including Translating Initiatives for Depression into Effective Solutions, focused on collaborative care for depression in primary care, which has demonstrated high levels of treatment engagement in veterans presenting with depression in primary care (Felker et al., 2006). Additionally, a clinical service, known as a Behavioral Health Laboratory (BHL), has been implemented in numerous VA medical centers. The mission of the BHLs is to provide comprehensive psychosocial assessments (with efficient,

same-day feedback summaries provided to each patient's clinician) for VHA patients in need of mental health care during primary care visits (Oslin et al., 2006). The BHLs have increased the detection of problematic substance use and suicidal ideation, symptoms which may have been missed in routine clinical practice, among veterans using VHA primary care services (Oslin et al., 2006). These existing and successful screening procedures and integrated care models make VHA primary care better equipped than perhaps any other health-care system to implement universal IPV screening.

Recognizing the potential benefits for patients, several national health care and advocacy groups and policies, such as the American College of Obstetricians and Gynecologists (2012), the Institute of Medicine (2011), the Patient Protection and Affordable Care Act (H.R. 3590—111th Congress: Patient Protection and Affordable Car Act), and Futures Without Violence (Family Violence Prevention Fund, 2004) advocate for universal IPV screening for women. In addition, the feasibility of implementing universal IPV screening programs within large, managed health care systems has been demonstrated through Kaiser Permanente's successful screening program (McCaw, 2011; McCaw & Kotz, 2009; McCaw, Berman, Syme & Hunkeler, 2001). Nevertheless, the VHA currently has no systematic program in place to identify patients' exposed to IPV. This reflects, at least in part, the linkage between VHA preventive health screening practices and guidance from the United States Preventive Services Task Force (USPSTF). Citing the poor quality and limited scope of the extant empirical literature on the utility of IPV-related screening, the USPSTF has historically viewed the available evidence on benefits and harms associated with IPV-related screening as inconclusive, offering a "C" grade for the quality of evidence supporting this practice (USPSTF, 2004; Nelson, Nygren, McInerney, & Klein, 2004).

Because the empirical evidence base supporting the utility of screening for IPV has historically been methodologically compromised as well as limited in scope and breadth, it is not surprising that health care environments, such as VHA, have not fully embraced universal screening practices. However, because USPSTF recently upgraded its recommendation for universal IPV screening to a "B" grade, this will inevitably change (USPSTF, 2012). Specifically, the 2012 USPSTF draft recommendations (USPSTF, 2012) now encourage primary care clinicians to screen all women of childbearing age (14–46 years, representing 42% of the female veteran population) for IPV and provide or refer women to intervention services when they screen positive. This recommendation for universal screening includes women who do not demonstrate signs or symptoms of abuse. Although this change indirectly reflects the existence of a somewhat larger and methodologically stronger literature base (Nelson, Bougatso, & Blazina, 2012), it is also linked to increased awareness that the creation of a traditional, empirical evidence base on this issue may not be possible. IPV is not a disease that can be isolated and easily studied with traditional epidemiological methods. Expectations for amassing a traditional evidence base have been replaced with an arguably more realistic perspective and nuanced appreciation that a) failure to screen women for IPV related risks dramatically reduces the likelihood of early identification and intervention, and b) eclipses the potential to study and refine best practices associated with screening.

The changing guidelines of the USPSTF are expected to influence practice within VHA. We now sit at the verge of the

adoption of a new practice that may offer unprecedented benefits to female veterans, including opportunities for critical safety intervention, validation of a high prevalence concern, as well as the development of long-term treatment planning for ongoing medical and mental health needs stemming from IPV exposure. Additionally, VHA will have the opportunity to implement a comprehensive and inclusive behavioral health screening in primary care (e.g. depression, substance use, PTSD, IPV) providing a platform for the development of both short- and long-term treatments for the sequelae of IPV exposure. However, the challenge lies in remaining committed to evidence-based practice. Specifically, with the commencement of systematic screening for IPV exposure, the VHA will need to systematically prepare its workforce to effectively identify and address unforeseen potential complications of screening—for example, those potentially introduced in circumstances where providers may treat both perpetrator and victim. It is also imperative that VHA systematically evaluate and address potential risks of screening within VHA that are not present in non-VA settings. For example, if a veteran's medical or mental health problems were inaccurately attributed exclusively to nonmilitary traumatic experiences appearing in the medical record, that could result in an unjust determination in a review for service-connected benefits.

In conclusion, the changing USPSTF recommendations for universal IPV screening among women of childbearing age provides the VHA with the opportunity to be at the forefront of developing an efficacious and systematic program to detect and treat consequences stemming from this highly prevalent health threat. There is the potential not only to increase prevention, detection, and treatment of victimization among female veterans but also to begin to address IPV in male veterans, a population at high risk for both IPV perpetration and victimization (Marshall et al., 2005; Taft et al., 2009; Teten, Sherman, & Han, 2009). The potential unknown risks and benefits of IPV screening in VHA call for implementation of universal screening to be accompanied by rigorous evaluation. VHA has a unique ability to longitudinally study the effects of implementing a universal IPV screening protocol owing its national, integrated healthcare system that encompasses a variety of practice settings, both urban and rural. VHA's unique qualities mean that it can play an integral role in informing, revising and improving best practices for IPV screening.

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