

An Evaluation of Intimate Partner Violence Services at a Pediatric Hospital

Mario Cruz, MD, FAAP

Assistant Professor of Pediatrics

St. Christopher's Hospital for Children

Drexel University College of Medicine

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Lutheran Settlement House

*Empowering Children, Adults, Families
and Communities since 1902!*

Disclosures

Dr. Cruz is on the speaker's bureau for the Institute for Safe Families but has no commercial conflicts of interest to disclose.



Intimate Partner Violence is a Pediatric Issue

**Eat your
vegetables.**

**Don't play
with matches.**

**Finish your
homework.**

**Respect
women.**



Barriers to IPV Screening

Personal Factors:

- ~~– Did not know that IPV was a pediatric issue~~
- ~~– Did not know how to screen for IPV~~
- ~~– Did not feel comfortable screening for IPV~~
- ~~– Forgot to screen for IPV~~

Systems-based factors:

- ~~– No protocol to manage positive screens~~
- ~~– Lack of time~~

CAMP- Children and Mom's Project

- Collaboration with:
 - Lutheran Settlement House's IPV Program
 - Institute for Safe Families
- Bilingual IPV counselor available 40 hrs/week
 - 4 days onsite
 - By pager on Fridays
 - Immediate and ongoing counseling services



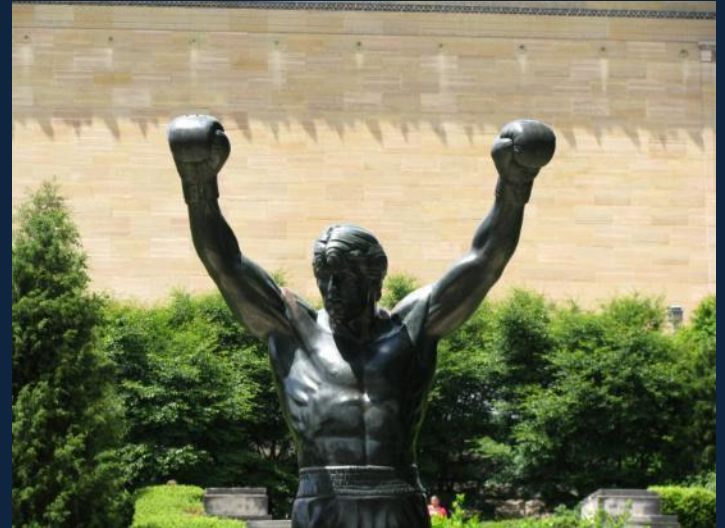
The SCHC Approach to IPV: Frequent Education

- IPV education built into:
 - Pediatric residency curricula
 - Nursing “extended core” curricula
- Hospital-based Departments
 - Offered training annually and upon request
- New employee orientation



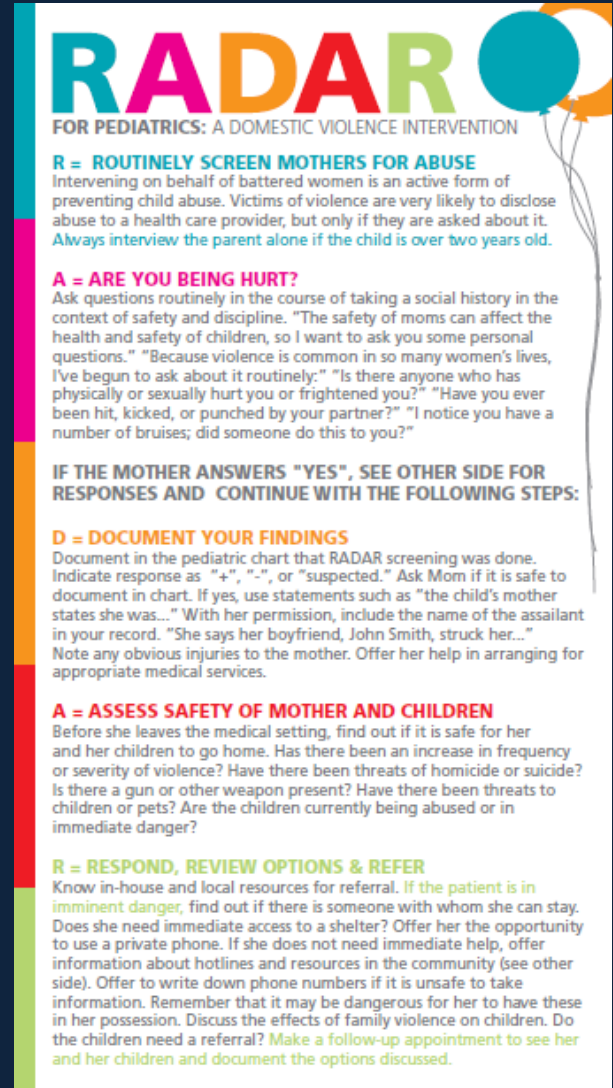
Utilization of IPV “Champions”


- From multiple disciplines:
 - Attending Physicians
 - Nurses
 - Social workers
 - Resident physicians
- Educate their colleagues on IPV
- Encourage screening for IPV
- Design protocols for IPV screening



IPV screening protocols

- All staff encouraged, but not expected to screen
- Verbal screening techniques
 - RADAR cards
- Do not screen if:
 - Another adult is present
 - Lack of privacy
- Caution if:
 - Child > 3 year old
- Document only with permission



RADAR 

FOR PEDIATRICS: A DOMESTIC VIOLENCE INTERVENTION

R = ROUTINELY SCREEN MOTHERS FOR ABUSE
Intervening on behalf of battered women is an active form of preventing child abuse. Victims of violence are very likely to disclose abuse to a health care provider, but only if they are asked about it. **Always interview the parent alone if the child is over two years old.**

A = ARE YOU BEING HURT?
Ask questions routinely in the course of taking a social history in the context of safety and discipline. "The safety of moms can affect the health and safety of children, so I want to ask you some personal questions." "Because violence is common in so many women's lives, I've begun to ask about it routinely." "Is there anyone who has physically or sexually hurt you or frightened you?" "Have you ever been hit, kicked, or punched by your partner?" "I notice you have a number of bruises; did someone do this to you?"

IF THE MOTHER ANSWERS "YES", SEE OTHER SIDE FOR RESPONSES AND CONTINUE WITH THE FOLLOWING STEPS:

D = DOCUMENT YOUR FINDINGS
Document in the pediatric chart that RADAR screening was done. Indicate response as "+", "-", or "suspected." Ask Mom if it is safe to document in chart. If yes, use statements such as "the child's mother states she was..." With her permission, include the name of the assailant in your record. "She says her boyfriend, John Smith, struck her..." Note any obvious injuries to the mother. Offer her help in arranging for appropriate medical services.

A = ASSESS SAFETY OF MOTHER AND CHILDREN
Before she leaves the medical setting, find out if it is safe for her and her children to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Is there a gun or other weapon present? Have there been threats to children or pets? Are the children currently being abused or in immediate danger?

R = RESPOND, REVIEW OPTIONS & REFER
Know in-house and local resources for referral. **If the patient is in imminent danger**, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity to use a private phone. If she does not need immediate help, offer information about hotlines and resources in the community (see other side). Offer to write down phone numbers if it is unsafe to take information. Remember that it may be dangerous for her to have these in her possession. Discuss the effects of family violence on children. Do the children need a referral? **Make a follow-up appointment to see her and her children and document the options discussed.**

Objective:

Describe the utilization of IPV services at St. Christopher's Hospital for Children

Methods

- Retrospective review of all IPV client charts
- 53 months between Sept 2005 - Feb 2010
- Medical records were *not* reviewed
- Inclusion criteria:
 - IPV victim identified by SCHC staff
 - IPV victim interested in IPV services
 - IPV victim received services from our IPV counselor

Methods:

Variables assessed

- IPV victim demographics
- Referral source
 - Hospital staff member
 - Hospital department
- Type of IPV screening
 - Routine vs. risk factor based
- Services provided by IPV counselor
- Rates of longitudinal service use



Results:

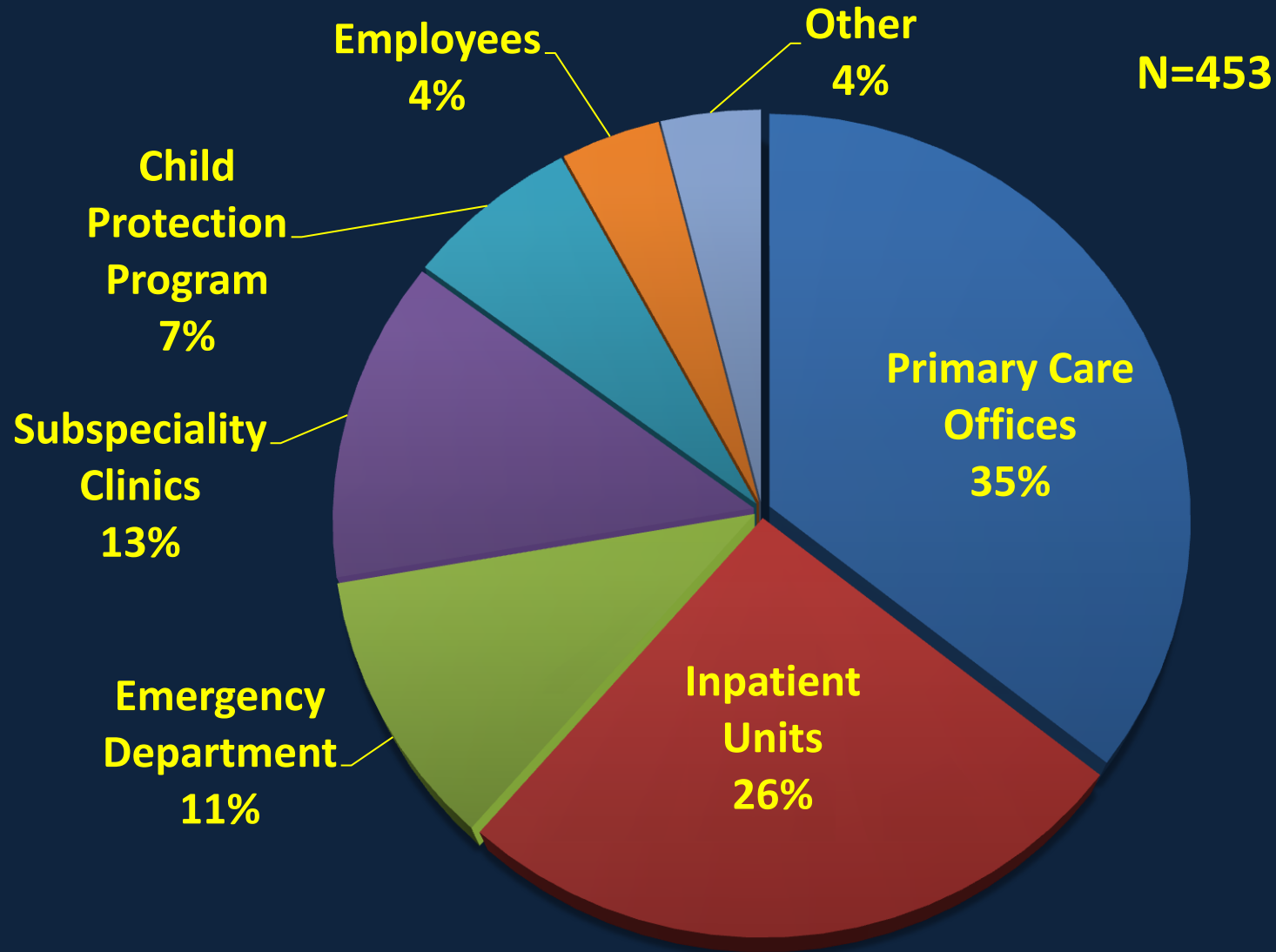
Number of IPV Victims Identified

- 453 unique IPV referrals over 53 months
 - 101 new referrals per year
 - Approx 8 new referrals per month
 - Range of 0 to 21 new referrals per month
- No identifiable temporal referral pattern

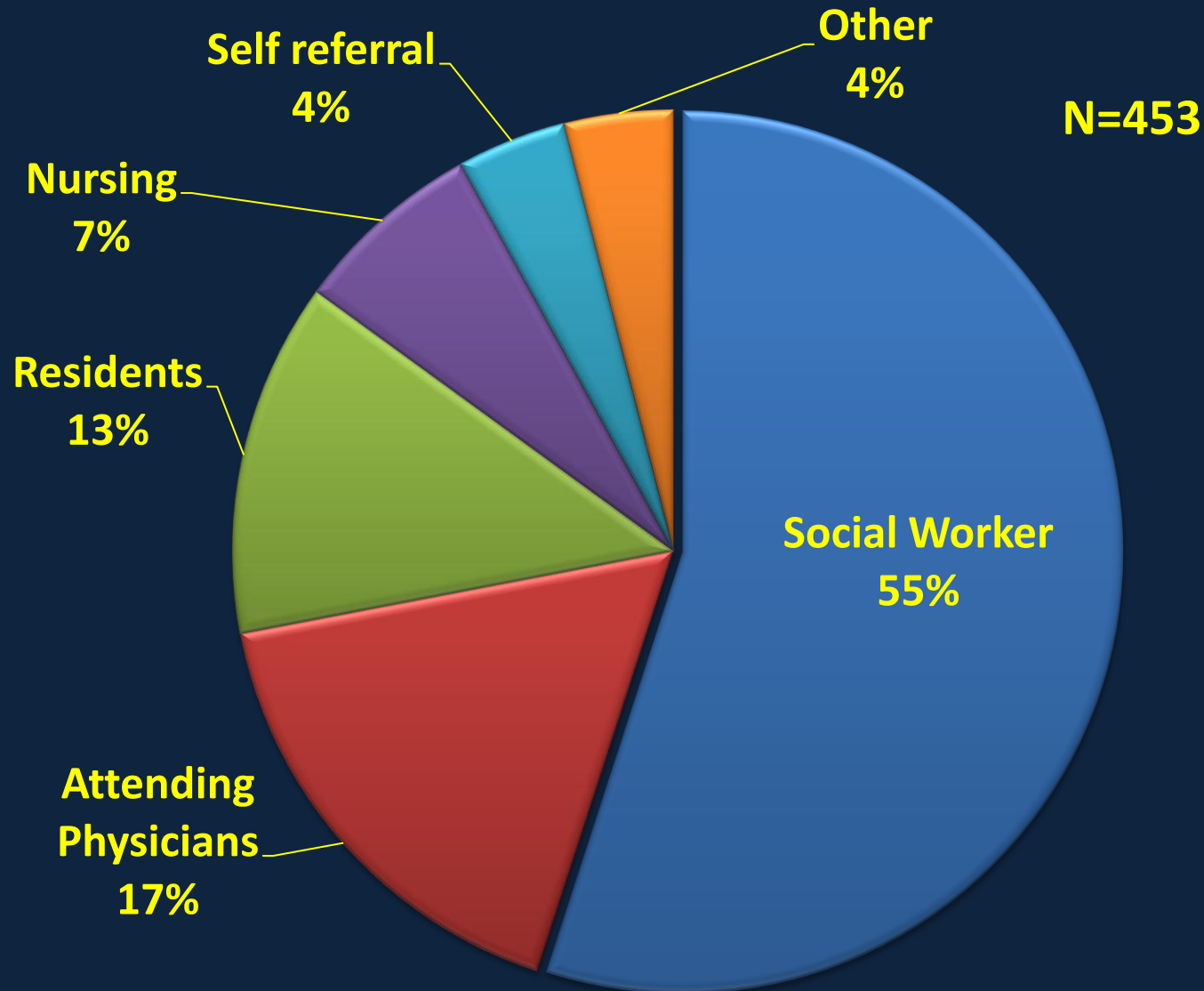
Demographics of New IPV Referrals

- IPV victim age
 - Range 14 – 71 yrs
 - Median of 24 yrs
- Number of dependents
 - 4% Zero
 - 41% One
 - 23% Two
 - 32% Three or more
- IPV victim gender
 - 100% Females
- IPV victim race
 - 44% Latina
 - 40% African American
 - 10% Caucasian
- IPV victim zip code
 - 33 zip codes

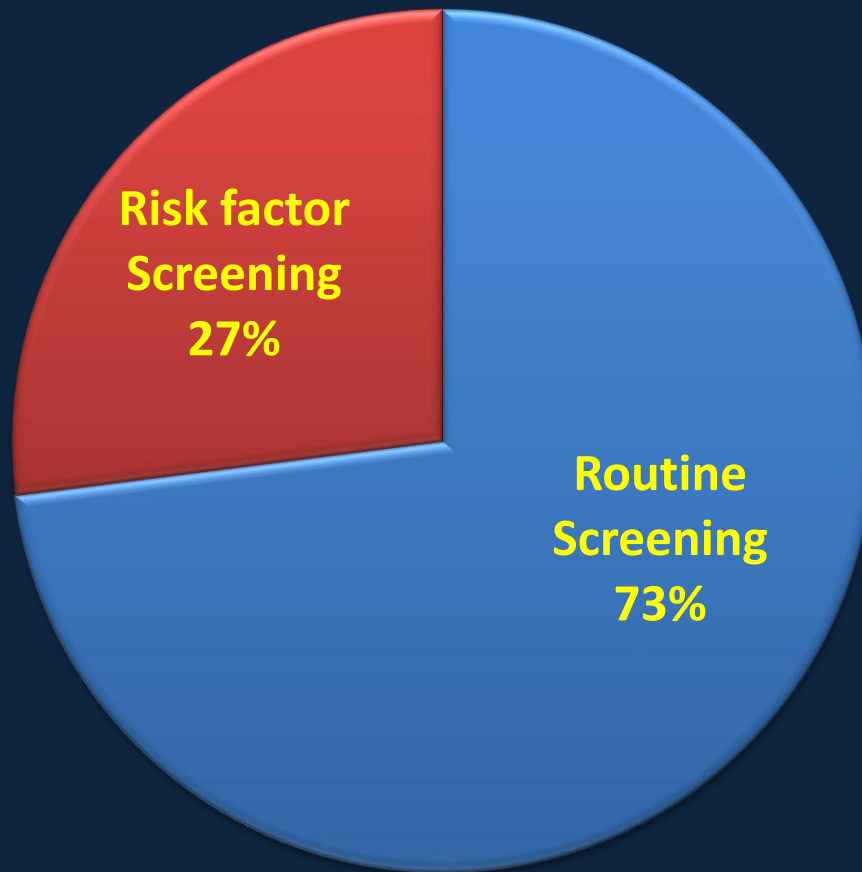
IPV Referral Source by Hospital Department



IPV referral source by hospital staff



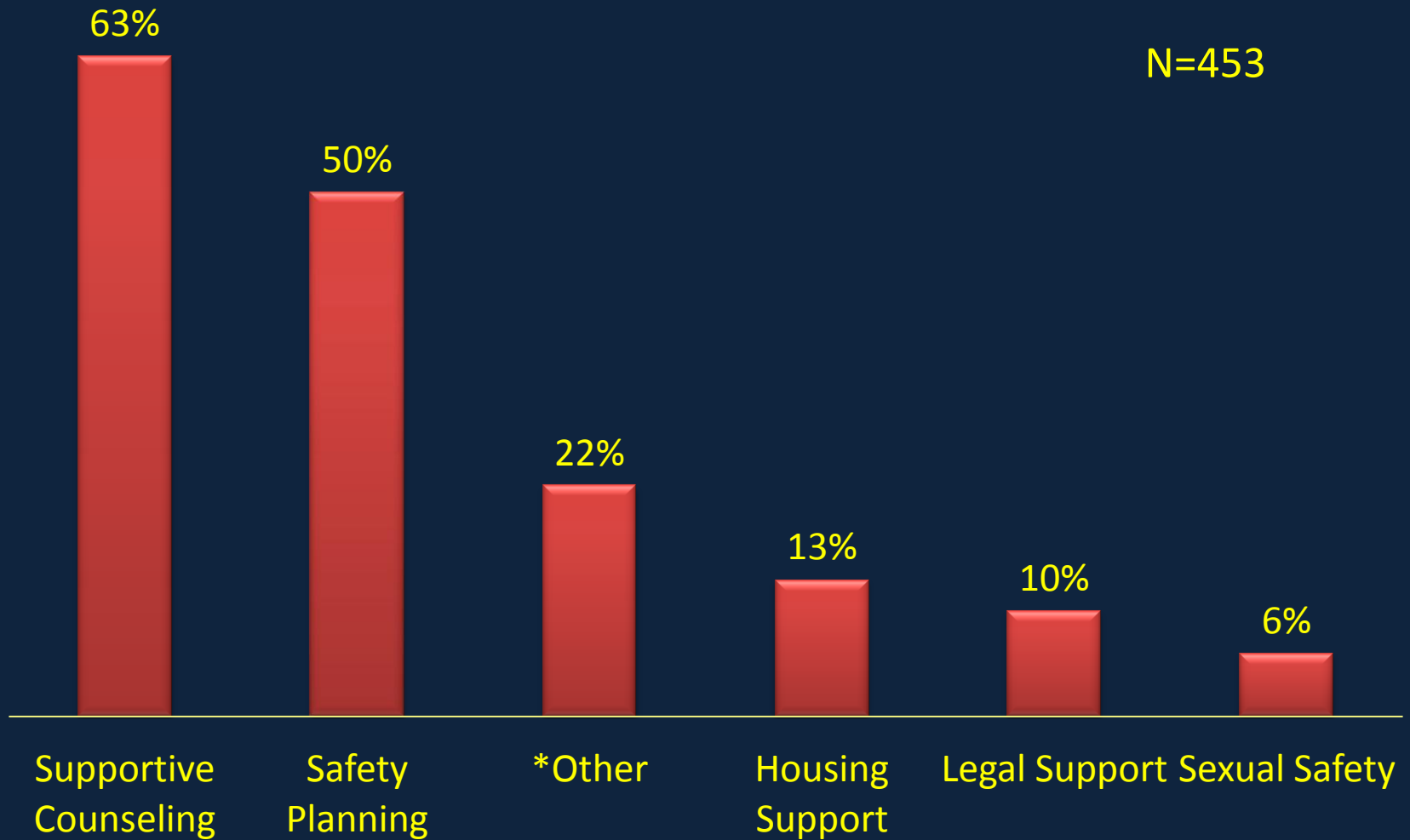
Type of screening used to identify IPV victim



N=277

IPV services utilized by new referrals

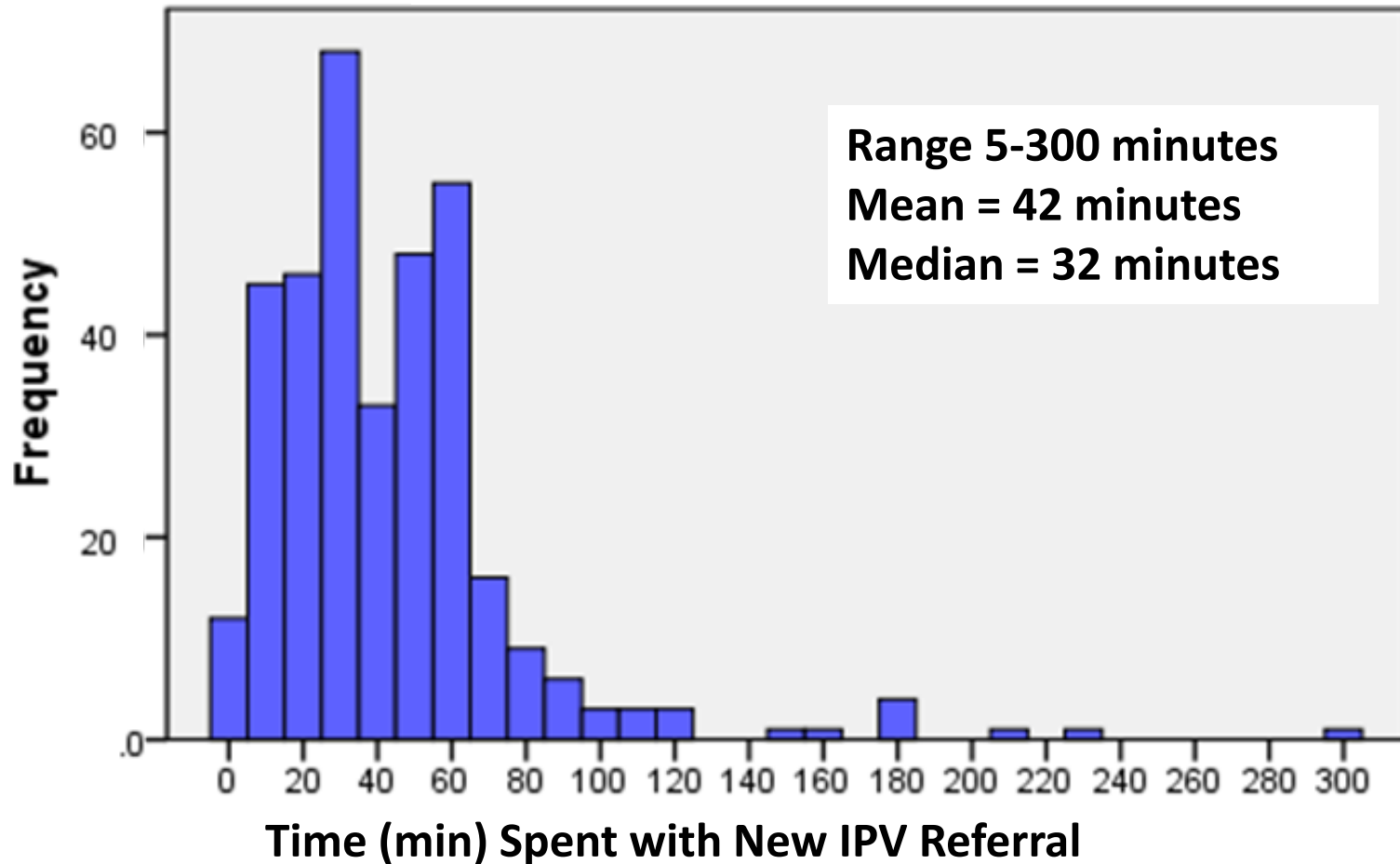
N=453



*Other= mental health referrals, in-kind donations, financial planning, social service advocacy.

Time required for IPV new referrals

N=453



Longitudinal IPV service utilization

- Longitudinal use:
 - > 3 encounters AND > 15 minutes of utilization
- 69% used services briefly
- 31% used services longitudinally

N=637	MEDIAN	MIN	MAX
# of contacts	2	1	218
# of Minutes	35	5	7720
# of Days	1	1	1289

More recently...

240 unique referrals in the last 12 months

3 former resident champions are now on the attending staff

Conclusions

- Hospital-wide IPV screening can be successful in pediatric settings
- Recommendations for other institutions:
 - *Routine* screening for both inpatient *and* outpatient settings
 - Supplement verbal screening with written screening
 - Designated IPV counselor
- Many QI opportunities exist



Thank you!

IPV counselors

Patricia Barry Cruz, LSW

Ramona Peralta, BA

Research assistants

Ryan McGorty, MPH

Christine Weirich, MPH

Program design and support

Martha Davis, MSS

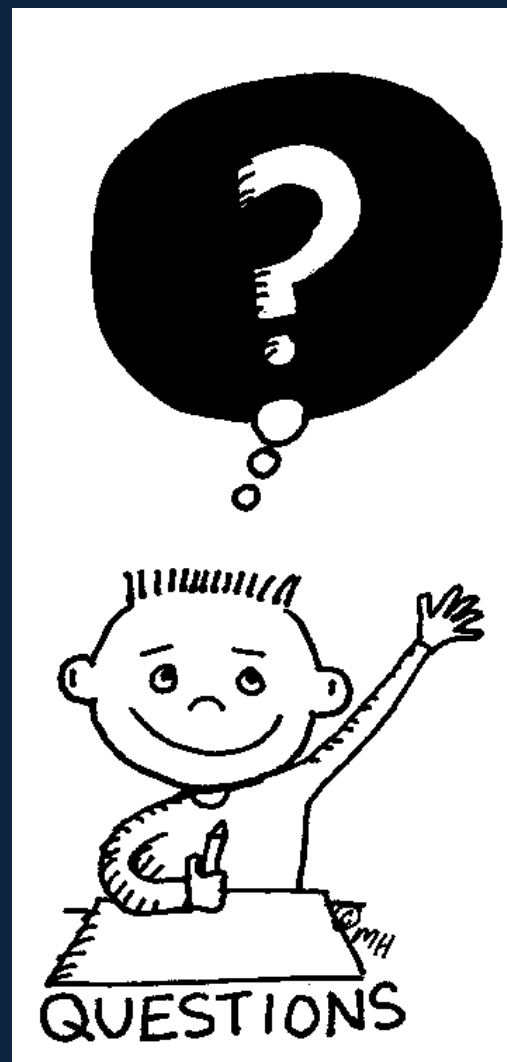
Cynthia Delago, MD

Sandra H. Dempsey, MSS

Angelo Giardino, MD

Maria McColgan, MD

Karen Vogel, LSW



All caregivers
n ≈ 450,000

Caregivers screened per protocol

Staff determined feasibility of IPV screening

Screened for IPV

IPV status disclosed

IPV positive caregivers enrolled in CAMP (n = 453)

NOT enrolled in CAMP

* Children > 3 years old
Caregiver was a man
Another adult present in room

* Barriers: privacy, discomfort, time, language discordance

* Inadequate screening techniques

* IPV Services not needed
Not willing to disclose IPV status

*Quality improvement opportunity

IPV referrals from resident clinic

