

At the Nexus of Substance Use Disorder and Intimate Partner Violence

By Jesse Nankin, MA, Laura Dietzen, MS, Scott Sangsland, MA, & Liza Eshilian-Oates, MD

Among women seeking treatment for addiction, as many as half have experienced intimate partner violence (IPV) in their lifetime—anywhere from two to five times more than the general population (Swan, Farber & Campbell, 2001; Schneider et al, 2009). Hazardous drinking and drug use—whether by the perpetrator, the victim or both—is not just associated with incidents of IPV, but also the severity level of the violence and injury (Mitchell & Anglin, 2009).

Emotionally, the combination of substance use disorder (SUD) and IPV is equally alarming. Rates of post-traumatic stress disorder (PTSD), depression, anxiety and phobias are all substantially greater for abused women in SUD treatment (Brady et al, 1994; Miller, Downs & Testa, 1993; Windle et al, 1995).

Unfortunately, coordination between SUD treatment programs and IPV services is the exception. Barriers to effective collaboration persist spurred by a lack of training on the complex presentations and impact of IPV, budget and time constraints, and the belief that addressing PTSD or IPV will do further emotional harm to a client or distract from the goal of sobriety (Swan et al, 2001). As a result, the IPV experiences of

women in substance abuse treatment are often not identified, monitored or addressed (Swan et al, 2001; Chermack et al, 2009; Shumacher, Fals-Stewart & Leonard, 2003).

This gap in care is a costly one, which only grows more expensive over time. The ripple effects of IPV extend well beyond physical and emotional health, affecting interpersonal and occupational functioning, and straining the resources of our health care system (Chermack et al, 2009). Annual health care costs for women experiencing ongoing abuse are 42 percent higher than non-abused women (Bonomi et al, 2009; Rivara et al, 2007).

Research conducted by the Southern California Permanente Medical Group and Polaris Health Directions, Inc., based in Wayne, PA, suggests that automated IPV screening of female and male patients entering treatment for SUD can substantially improve detection.

Beyond screening, the project ultimately seeks to demonstrate the plausibility of addressing IPV and addiction concurrently. Doing so may improve the rate of completing substance abuse treatment, lower the likelihood of relapse, and ultimately lead to lower health care costs (Pirard et al, 2005; Easton, Swan & Sinha, 2000; Swan et al, 2001).



Establishing Best Practices

Better Screening, Better Follow Up

In 2007, Kaiser's Southern California addiction medicine clinics implemented a best practices model for identifying and addressing IPV. Initially developed in Kaiser's Northern California region, the "Systems Model for IPV Prevention" is centered on five components:

1. An open and supportive environment for addressing IPV
2. Protocols for inquiry and referral across all medical departments
3. On-site IPV services
4. Relationships with community IPV resources
5. Receptive leadership and oversight.

Initially, there was no standard protocol to assess for and follow up on IPV. Clinicians were expected to remember to ask, but the method and effectiveness of the inquiry varied. Detection rates ranged widely across Kaiser's clinics, and those cases that were detected were not always documented in Kaiser's electronic health record (EHR) system. When intimate partner violence is not diagnosed and documented, there is little basis for evaluating health risks in the future.

To strengthen and standardize their efforts, the Southern California division partnered with Polaris Health Directions to develop a systematic and reliable method to achieve the goals outlined in Kaiser's best practices model. Comprehensive training and securing the support of clinicians, caseworkers, and administrators for addressing IPV in routine SUD treatment were key to these efforts.

Having the Right Tools, Asking the Right Questions

Since 2001, Kaiser's Southern California addiction medicine clinics have been using a substance abuse treatment support system (SATSS) to assess the impact of services, and improve the quality of care and patient outcomes (Grissom et al, 2004). Developed with funding from the National Institutes of Health, the cloud-based system enables providers to securely collect, store, process, and report information relating to a patient's clinical status and progress in real time. It also provides a structure for the evaluation of outcomes and the monitoring of treatment response.

The patient assessment includes demographic items and questions relating to treatment history, motivation, strengths, and risk factors for dropout and relapse. Quantitative measures include the severity of symptoms of depression and anxiety, and severity of alcohol, drug, psychiatric, family/social, employment and medical problems, based upon the Addiction Severity Index. Prior to 2007 it also incorporated four items that asked about a history of child or adult abuse, but, again, no standard protocol for those who responded affirmatively (McLellan et al, 1992).

Between 2007 and 2009, Kaiser and Polaris worked together to incorporate new IPV screening questions into the assessment of past and current abuse. These added questions were designed as risk adjusters for the prediction of substance abuse disorder outcomes, including dropout and relapse. They were:

- Have you been the victim of spousal abuse?
- Were you physically or sexually abused as a child?
- Have you been the victim of physical abuse as an adult?
- Have you been the victim of sexual abuse as an adult?
- Within the past 12 months, has your partner hit, slapped, kicked, choked or otherwise physically hurt you?
- Are you afraid of your partner?

- Within the past 12 months, has your partner forced you to participate in any unwanted sexual activities?

In 2013, two additional items were included, asking about family violence within the past 30 days, and three of the original family violence questions were omitted.

As IPV items were added to the assessment, corresponding changes were made to the SATSS clinical reports. These included linking affirmative statements, such as the "patient was a victim of physical abuse in the past 12 months," to diagnostic codes that could be entered into Kaiser's EHR system. This improved the chances that the clinician would act on the information provided by the report, while also providing a foundation for future follow-up by other providers within the Kaiser system.

In 2009, the IPV information was moved to the first page of the assessment report, and counselors were instructed to initiate a conversation with patients if current abuse was indicated. Additionally, several treatment goals related to IPV were established and shared with the Kaiser treatment staff for the day-to-day care of patients with SUD experiencing IPV. These included working to ensure the patient's safety and helping the patient think clearly, trust his or her own decisions, feel less anxious and avoidant, and establish support connections and boundaries.

Supporting the New Culture

Understanding that many providers find it difficult to discuss abuse, comprehensive training was required for treatment staff. Clinicians were instructed to validate and affirm the abuse with phrases such as: (1) "You are not alone. Help is available;" (2) "You do not deserve to be treated this way. It's not your fault;" and (3) "I am concerned about your safety, and how this may be affecting your health." They were given in-person training on how to obtain additional information, document it, and to make the appropriate referrals to community IPV agencies.

Other tools developed to assist clinicians in identifying and responding to IPV included a regional website that provides area-specific mandatory reporting instructions; forms and important phone numbers; bilingual patient brochures and wallet cards that contain area-specific contact numbers and safety information; and the provision of resource information and safety planning for patients exposed to IPV.

The strategic approach employed by Kaiser and Polaris had an immediate effect in identifying IPV. As shown in the chart below, in 2008, six patients seeking treatment for SUD were coded into the EHR for abuse. By the next year, the number had increased dramatically (McCaw, 2011).

An Encouraging Start to Integrating Care

There are several factors that have contributed to the initial success of this project.

First, the idea of incorporating assessment items relating to IPV was never presented as a "DV screener," but rather as a vital part of improving overall health care for patients with SUD. The new content was

Year	Self-Reported Abuse Rate *	# of Patients with Abuse Coded in EHR	Abuse Rate Coded in EHR *
2008	177.26	6	0.91
2009	161.36	224	31.16
2010	152.24	508	83.43
2011	156.45	567	89.15
2012	161.86	427	57.01
2013	141.52	284	32.86

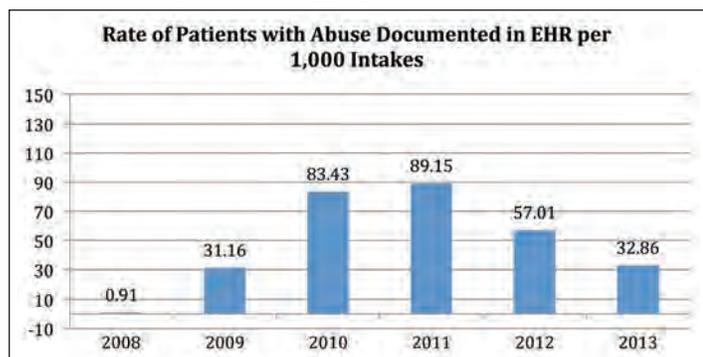
embedded in a system with which clinical staff were familiar, giving them confidence that this change to their clinical workflow was likely to be effective. Also working in the project's favor was awareness among Kaiser's management and clinical leadership that IPV is strongly associated with chronic diseases and rising health care costs.

Clinicians were given the support they needed to detect and document IPV and then discuss it with their patients, using information on the reports to guide the dialogue. Adding diagnostic codes to the reports provided a reliable link to Kaiser's EHR, and reinforced the value of addressing IPV on a regular basis. In support of consistent IPV coding, Kaiser management established performance goals related to continual monitoring of IPV coding and matching it to detection data from the system.

The SATSS platform has also been critical to facilitating the project. What might have seemed unrealistic 20 years ago is now greatly simplified with outcomes management technology. Kaiser staff have reported that the automated assessment allows patients to convey potentially shameful information without having to worry about how it is perceived by a "real" person. Research supports this premise—with many patients preferring a computer-based screener to face-to-face interviews with a health care provider (MacMillan et al, 2006; Rhodes et al, 2002; Klevens et al, 2012).

The platform used has also helped to standardize the screening process, lessening the likelihood that a person experiencing IPV remains unnoticed. Other benefits have included improved data quality, reduced response bias, and the ability for patients to respond only to questions relevant to their situation (response-adaptive logic) (Renker, 2008).

Perhaps most importantly, with an automating screening process, staff have had more time to spend on counseling, assessing the severity of the abuse, and finding additional appropriate referrals.



But There is Always Room for Improvement

As shown in the graph above, there was a dip in the number of new patients coded in Kaiser's EHR between the years 2011 and 2013. This fluctuation can be attributed to two factors. First, the decision was made to focus upon patients with current (past 30 days) or recent (past year) victimization—those for whom domestic violence would need to be addressed in the treatment plan. Some codes were no longer printed on the SATSS reports for patients reporting more distant victimization, resulting in a 30 percent reduction in the number of patients for whom the counselor was prompted to enter a code in the EHR.

When these prompts were discontinued, many counselors did not take the initiative to enter codes for patients with a past history of victimization if it occurred more than a year ago and was not a current concern. This accounts for most of the decline, and underscores the importance of the prompts appearing on the reports.

Second, the decline can be linked to a training deficit, including not reinforcing the importance of IPV screening and coding among staff on a continuing basis. These results offered two lessons: the need for periodic reporting of aggregate data to alert staff as soon as possible to negative trends and for training to compensate for attrition.

Within this quarter, Kaiser plans to initiate a system to ensure regular reporting and refresher training courses. It is expected that these program modifications will lead to an uptick again in coding for IPV.

The next phases of this project will explore the effect on medical outcomes of improved detection and management of IPV and its physical and emotional manifestations. New family violence measures, including scales for PTSD and Abuse Adjustment, are being added to SATSS, and a pilot study will be launched to assess the impact of IPV on substance abuse treatment engagement and long-term outcomes. The project may also offer the opportunity to better understand the prevalence and impact of victimization among men seeking treatment for substance abuse disorder, as well as the value the IPV data offer to improve overall clinical care for all patients.

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