Intimate Partner and Sexual Violence at U.S. Trauma Centers

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Background

• Intimate partner violence is a form of interpersonal violence:
  – Physical, psychological, sexual

• Intimate Partner Violence and Sexual Violence (IPSV) are independent risk factors for: (Campbell et al, 2003)
  – Mental illness & substance abuse
  – Injury (secondary to violence or not)
  – Homicide

• IPSV can thus lead to increased trauma or death
Background

• Screening for IPSV has been a national priority
  – Needed for JCAHO accreditation starting in 1992
• But has tended to focus on women only, with suspicious injury patterns, and excluded screening for sexual violence (Kothari, 2014; Flanagan, 2013; Ulloa, 2014)
  – Bi-directionality of violence occurs
    • Men have a higher injury-related hospitalization rate (3x)
    – Men are not immune to sexual violence
• Screening by MDs, especially surgeons, is difficult (Gotlib, 2014)
  – Attitudes & barriers to screening are varied
    • Differences between the screeners and the screened
Therefore

• Post-injury transport to a trauma center represents a unique opportunity to engage in **universal** screening:
  – Women and men
  – Including sexual violence
  – Independent of injury pattern

• A cycle of violence can be broken
  – Interpersonal violence or non-intentional trauma
Our own data shows

• **Universal screening is possible** early, by non-MDs, in a trauma center with ethnic & cultural diversity
  – HITS & SAVE questionnaires (8 questions, 4 minutes)

• **The prevalence of IPSV is high**
  – physical and psychological trauma (14%)
  – sexual violence (8%)

• **Equal rates between men and women**, across all ages and ethnic groups

• Most patients who screened positive were **not** admitted due to interpersonal violence (86%)
“Not even my wife knows.”
Hypothesis

• IPSV is equally prevalent among trauma populations in other Level I/II trauma centers across the US
  – Not merely a Miami phenomenon
  – Screening by allied health care workers is feasible

• Patients who screen positive for IPSV have higher rates of all-trauma recidivism

• Attitudes and barriers to screening are unique at each center
  – What are they?
  – How do they differ between the screeners and the screened?
Goal

• To make universal IPSV screening a requirement for trauma center accreditation (similar to the Brief Alcohol Intervention)
  – Probably lead to a reduction in IPSV-related homicide
  – Probably lead to a reduction in recidivism for IPSV
  – Possibly lead to a reduction in recidivism for all trauma
    • Issues of stigma & shame
Methods

• This will be a **multicenter, cross-sectional study** for universal screening to detect the prevalence of IPSV

• Data will be generated **prospectively** at each site by universal screening of all trauma patients
  – Done by allied health care professionals who do screening routinely

• **Inclusion:** adult men and women, prisoners, pregnant women & trauma centers with available social workers to screen

• **Exclusion:** minors, unexaminable patients

• **Variables:** demographics, mechanism of injury, self-reported previous injury, perceptions of screening

• **Screening:** HITS & SAVE questionnaires
Methods Analysis Plan

• Descriptive statistics for:
  – Demographics
  – Recidivism
  – Screening tools (HITS & SAVE)
  – Standard statistical tests for:
    • Comparison between groups that are IPSV +/-
    • Student’s t-test / Z-test for continuous variables and chi-squared (+/-Fischer’s exact test) for categorical variables
Progress / Needs

• Progress
  – Single center data already collected

• Needs for participating centers
  – Social workers or other allied health care professionals available for screening
  – IRB at host institution granted under exemption
    • As standard of care already, simply expanding criteria for screening
Goals / Timeline

• Recruitment of centers now
• Standardize study tools to local centers to ensure universal screening (February, 2015)
  – Local IRB applications (February, 2015)
• Prospective data collection over 6 months
  – (March 2015 – August 2015)
• Data ‘cleaning’ & multi-center meeting at AAST
  – (September, 2015)
• Statistical analysis & write-up (October, 2015)
• Goal: EAST submission 2016
We Need Your Help – Please Join Us
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