Screening for Intimate Partner Violence in a London HIV clinic: characteristics of those screening positive

Madge S[1], Smith C[2], Warren-Gash[3], C, Bayly J[4], Bartley A[5].

1.Sara Madge, Ian Charleson centre for HIV Medicine, Royal Free, London NHS Foundation Trust. NW3 2QG
2.Colette Smith Research Department of Infection and Population Health, University College London. NW3 2QG
3.Charlotte Warren-Gash, Institute of Health Informatics, University College London.
4.Jude Bayly, Maternity Department, Royal Free, London NHS Foundation Trust. NW3 2QG
5.Angela Bartley, Public Health Department, Royal Free, London NHS Foundation Trust. NW3 2QG

Acknowledgments. R Watts and staff who helped carry out screening.

Intimate Partner Violence (IPV) is widespread and more prevalent in the HIV positive population (1). However there is little published work concerning IPV in this population in the UK (2). Dhairyawan et al (3) found a 52% lifetime prevalence of IPV in HIV positive women in a London clinic, with 14% reporting IPV in the last year. Health Care Workers have been identified as professionals to whom patients might choose to disclose IPV (4).

Screening for IPV is recommended in selected health care settings, and at our hospital there is a new post for an Independent Domestic and Sexual Violence Advisor (IDSVA). We established screening in an Out Patient HIV clinic and compared those screened with those not, and summarised the characteristics of those reporting current or previous IPV.

Multidisciplinary staff were trained to ask the following standardised question: "Have you ever been emotionally or physically hurt by your partner, ex-partner or family member?" Those who answered positively were assessed for current or past IPV by asking, "Are you still in contact with this person and are they still causing you and your family issues?" Screening took place while the patient was alone in a private place. Patients were referred to Safeguarding services if necessary and to the IDSVA. If referral to the IDVSA was declined or there was no current risk, leaflets and contact information was given.

We report on the demographics of 348-screened patients. Data were collected over 5 months and recorded on a standardised sheet and linked to the HIV database by hospital number and then anonomysed. Groups were compared using chi-squared tests or Fisher's Exact test for categorical variables, and using Mann-Whitney U tests for continuous variables as they were not Normally distributed. No formal adjustment for multiple testing was made.

10% (348/3383) of the current clinic population was screened. Those screened had similar demographics and HIV markers to those not screened. Almost a third of participants (103/348,30%), had ever experienced IPV, and were more likely to be female (p=0.01) with a trend towards heterosexual risk group (p=0.085) and a detectable viral load (p=0.088). 68/348(20%) had experienced IPV in the past and 35/348(10%) of those screened were experiencing current IPV or were given contact information for future self referral. 14/348(4%) agreed to be referred to the IVDSA. Ten were women and 7/14 had Black ethnicity. Other variables were similar to the whole population except seven of those referred had detectable viraemia (50% vs. 15%). Although numbers are small perhaps this

may suggest a relationship between adherence and access to medication, which could be further explored. Among the 103 who screened positive as a group there was also a trend towards detectable viraemia (p=0.088)

There was evidence of differences also when comparing men whom screened positive for IPV according to risk group. Of the 224 men who were screened, 54 (24.1%) reported previous or current IPV. When stratifying by risk for HIV acquisition, 38/119 (24.2%) MSM, 6/44 (13.6%) of heterosexual men, 9/16 (56.3%) of IDU and 1/8 (12.5%) of other risk men reported current/previous IPV (p=0.0326).

There was no evidence of a difference by age (see Table 1). Furthermore, the median (range) age of men who were screened for DV was 48 (18-75) years and the median age of women was 44 (16-77) years. When included in the multivariable logistic regression model, the estimate for men vs women was materially unchanged (OR=0.34; 95% CI 0.15-0.75; p=0.0080).

Compared to other specialities in our hospital undertaking screening, IPV was more commonly reported, for example 5.7% in GUM services (5). This may be because those with HIV are a more vulnerable group. Screening was often performed by a person with whom the patient had a long-standing relationship, which may encourage disclosure.Those whom experienced past IPV were offered referral to the Psychology service. Future work could look at age/gender-matched controls across different hospital departments. This pilot suggests the pathway is robust and a variety of staff could be successfully trained.

There are limitations to this study, which could be explored in future work. Although the relationship of the perpetrator to the victim was known it was not recorded on the screening proforma. Neither was the nature of the IPV, which was wide ranging including physical, verbal and sexual abuse, blackmail and financial control, threats to disclose HIV status and with-hold Antiviral medication (personal communication S. Madge). We did not record education or employment demographics.This screening tool was useful as it included" a family member" as a possible perpetrator, and this could contribute towards the relatively high detection rate of IPV.

HIV positive patients experience a high lifetime risk for IPV and warrant further investigation as a high-risk group. A Clinic setting appears to be an appropriate venue for screening and referral by a variety of Health Care workers using this tool and pathway. Staff reported that although screening was sometimes time consuming they felt it improved their satisfaction with the consultation. Patients could also be asked about their experience and opinion. More patients should be screened with more detailed data recorded to establish common factors for those at highest risk. The possible relationship between viral load and current IPV merits further exploration. Detectable viraemia might be a trigger for discussion about IPV in the HIV clinic.

References

1) Siemieniuk RA, Krentz HB, Gill MJ.Curr Intimate partner violence and HIV: a review. *HIV/AIDS Rep*. 2013 Dec; **10**(4): 380-9.

2) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively
NICE guidelines [PH50] Published date: February 2014

3) Dhairyawan R, Tariq S, Scourse R, et al. Intimate partner violence in women living with HIV attending an inner city clinic in the UK: prevalence and associated factors. *HIV Med*. 2013 May; **14**(5): 303-10. Epub 2012 Dec 6.

4) Khalifeh H, Oram S, Trevillion K, et al Recent intimate partner violence among people with chronic mental illness: findings from a national cross-sectional survey. *Br J Psychiatry*. 2015 Sep; **207**(3): 207-12 Epub 2015 Jun 4.

5) Outcomes of domestic violence screening at an acute London trust: are there missed opportunities for intervention?
Warren-Gash C, Bartley A, Bayley J, et al *BMJ Open* 2016;**6**:e009069 doi:10.1136/bmjopen-2015-009069

Table 1- Characteristics, according to whether individual was screened or not and whether individual had ever experienced IPV

	All screened	Positive screen	Negative screen	Not screened	P (Screened vs not screened)	P (positivescreen vs negative screen)
N	348	103	245	3035		
Male gender	224 (64.4%)	54 (52.4%)	170 (69.4%)	2286 (75.3%)	<0.0001	0.01
Age (years) Median (range)	47 (16, 77)	46 (25, 77)	47 (16, 77)	46 (17, 86)	0.73	0.79
Ethnicity					0.0227	0.37
White	172 (49.4%)	50 (48.5%)	122 (49.8%)	1734 (57.1%)		
Black African	97 (27.9%)	25 (24.3%)	72 (29.4%)	725 (23.9%)		
Other	79 (22.7%)	28 (48.5%)	51 (20.8%)	576 (19.0%)		
Risk					0.0017	0.085
MSM	157 (45.1%)	38 (36.9%)	119 (48.6%)	1666 (54.9%)		
Heterosexual	154 (44.3%)	50 (48.5%)	104 (42.5%)	1135 (37.4%)		
Other	37 (10.6%)	15 (14.6%)	22 (9.0%)	234 (7.7%)		
Time in years since diagnosis Median (range)	11.5 (0.0, 29.5)	11.3 (0.2, 27.7)	11.5 (0.0, 29.5)	11.1 (0.7, 34.3)	0.94	0.77
Ever had AIDS diagnosis	90 (25.9%)	25 (24.3%)	65 (26.5%)	791 (26.1%)	0.0675	0.66
CD4 nadir cells/mm3	194 (0, 1368)	200 (0, 1368)	188 (1, 783)	199 (0, 1700)	0.83	0.43
CD4 current cells/mm3	568 (9, 1604)	576 (114, 1604)	566 (9, 1501)	606 (1, 2295)	0.11	0.75
VL<50 cps/ml	291/339 (85.8%)	80/99 (80.8%)	211/240 (87.9%)	2593/3021 (85.8%)	1.00	0.088
Total length of ART in years	9.7 (0.2, 23.9)	9.6 (0.2, 22.3)	10.2 (0.4, 23.9)	9.5 (0.0, 27.5)	0.99	0.68

Table 2- Characteristics, according to whether whether individual had ever experienced DV, further stratified by gender

	Women		Men	
	Positive screen	**Negative screen**	**Positive screen**	**Negative screen**
N	49	75	54	170
Age (years)				
Median (range)	44 (25-77)	44 (16-77)	48 (31-67)	48 (18-75)
Ethnicity				
White	11 (22.5%)	11 (14.7%)	39 (72.2%)	111 (65.3)
Black African	29 (59.2%)	49 (65.3%)	4 (7.4%)	36 (21.2)
Other	9 (18.4%)	15 (20.0%)	11 (20.4%)	23 (13.5)
Risk				
MSM	-	-	38 (70.4%)	119 (70.0)
Heterosexual	44 (89.8)	66 (88.0)	6 (11.1)	38 (22.4)
Other	5 (10.2)	9 (12.0)	10 (18.5)	13 (7.7)
Time since diagnosis (years) Median (range)	11.5 (1.3-25.2)	10.5 (0.2-23.9)	10.9 (0.2-27.7)	11.8 (0.0-29.5)
Ever had AIDS diagnosis	13 (26.5)	21 (28.0)	12 (22.2)	44 (25.8)
CD4 nadir (cells/mm^3)	200 (0-452)	187 (7-783)	198 (150-1604)	189 (1-707)
CD4 current (cells/mm^3)	534 (114-1055)	560 (123-1369)	637 (150-1604)	566 (9-1501)
VL<50 copies/ml	34 (75.6)	63 (90.0)	46 (85.2)	148 (87.1)
Total length of ART (years)	9.6 (0.2-22.3)	9.5 (0.6-23.9)	9.4 (0.2-20.9)	10.2 (0.4-23.9)