IPV in HIV patients receiving care

Dr M John Gill

S Alberta HIV Program ,Canada

Background

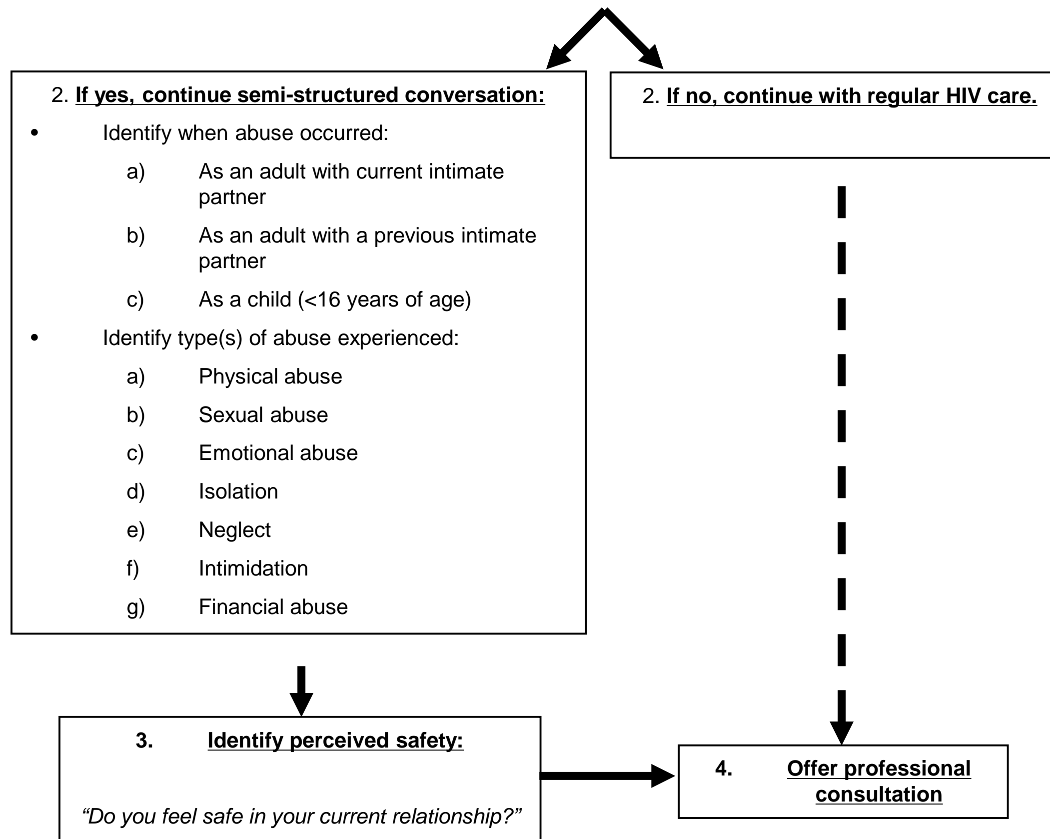
- Following a fatal IPV incident in an HIV patient in our program, screening of all patients was introduced
- High prevalence across all HIV risk groups documented
- IPV : Prevalent not only in HIV women but also in men, especially MSM .
- Highest risk of IPV in First Nations (aboriginal)
- A measurable negative impact on health identified including engagement to HIV care, mental health, as well as social stability

HIV Med 2013 :14,293-302 & JAIDS 2013:64(1): 32-38

Screening interview algorithm

1. **Screening Question**

"Domestic violence and the threat of violence in the home is a problem for many people at SAC and in the community; this can directly affect health. Abuse can be a problem in relationships from all cultures and sexual orientations, and can take many forms: physical, sexual, emotional, isolation, neglect, intimidation or financial.
We routinely ask all patients about domestic abuse in their lives. This often brings up many strong emotions, including different types of fear and uncertainty, but rest assured that this is a safe place to discuss this issue. Have you or your children) ever experienced domestic abuse in any way?"



1. Siemieniuk RA, et al. AIDS Patient Care STDS. 2010;24:763-70

High-risk groups

	DV, including childhood abuse	IPV as an adult
All	35%	23%
Women	46%	40%
Aboriginal Canadian	67%	46%
Aboriginal women	81%	65%
Gay/bisexual men	35%	22%
IDU	54%	32%

AIDS Patient Care and STDs 2010 24 763 -770

Screening for IPV

- Initially we introduced program using a tool from sexual assault program administered by clinic nurses during routine HIV visits
- Now screened over 80% of > 1600 patients
- Support protocol in place for IPV +ve patients
- We were challenged that we could be re-traumatizing our patients and we should wait for them to raise topic
- So, we surveyed our patients asking if and how IPV screening should be addressed

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Implementing IPV screening

- In-depth interviews with 158 SAC patients screened for IPV

N (%)	*Total* 158	*IPV+*[b] 103 (65)	*IPV-*[c] 55 (35)	p *Value*
1. Should IPV screening be part of routine of HIV care?				
Yes	115 (73)	73 (71)	42 (76)	<0.0001
No	25 (16)	20 (19)	5 (9)	
No preference	15 (9)	8 (8)	7 (13)	
No answer provided	3 (2)	2 (2)	1 (2)	
2. What would be the optimal time for IPV screening?				
Beginning of HIV care	49 (31)	29 (28)	20 (36)	<0.0001
Following a couple of clinic visits	83 (53)	55 (53)	28 (51)	
No preference	26 (16)	19 (18)	7 (13)	
3. Which healthcare worker should ask about IPV?[d]				
Clinician	32 (20)	19 (18)	13 (24)	
Nurse	33 (21)	22 (21)	11 (20)	
Social worker	21 (13)	15 (15)	6 (11)	
No preference	82 (52)	53 (51)	29 (53)	n.s.
4. Which gender should ask about IPV?				
Female	34 (22)	27 (26)	7 (13)	<0.0001
Male	7 (4)	2 (2)	5 (9)	
No preference	117 (74)	74 (72)	43 (78)	

Implementing IPV screening

- In-depth interviews with 158 SAC patients screened for IPV

5. What type of question should be asked?[e]				
	n = 120	n = 66	n = 54	
"Are you currently experiencing any forms of abuse including physical, psychological, sexual, intimidation, neglect, isolation, and economic, within your relationship?"	60 (50)	32 (48)	28 (52)	<0.0001
"Are you currently experiencing any stress within your relationships?"	29 (24)	17 (26)	12 (22)	
"Are you currently experiencing any stress within your relationships that is due to an abusive situation?"	26 (22)	14 (21)	12 (22)	
No preference	5 (4)	3 (5)	2 (4)	
6. Should questions on IPV be asked in follow-up visits?[f]				
	n = 96	n = 44	n = 52	
Yes	93 (97)	42 (95)	51 (98)	<0.0001
No	3 (3)	2 (5)	1 (2)	
7. How frequently should questions on IPV be asked?				
Every clinic visit	65 (41)	46 (45)	19 (35)	
Every 6 months	49 (31)	31 (30)	18 (33)	
Annually	27 (17)	13 (13)	14 (25)	
No preference	17 (11)	13 (13)	4 (7)	n.s.

Table 4. Recommendations to Implementing an IPV (Intimate Partner Violence) Screening Program in Routine HIV Care

1. A universal IPV screening protocol should be incorporated within regular HIV clinic care.
2. A "trusting relationship" should be established before any questions about past or present IPV are asked.
3. Any healthcare provider can inquire about IPV as long as there is an established trust relationship.
4. Provide a clear and easily understood definition of abuse when inquiring about IPV.
5. A referral process for those identified with IPV exposure needs to be in place either in house or in the community.
6. Regular and routine follow-up with patients who have disclosed experiencing abuse in current relationship should be conducted.
7. Routine inquiry should occur at least annually regardless if the patient previously screened negative for IPV.

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IPV and Housing

- During routine visits we have collected information on housing stability in ~ 2000 patients over 6 years
- 17% had experienced recent housing instability homeless/temporary or supported housing
- Strong relationships with Alcohol use/IDU/Sexual activity and incarceration
- Low CD4 count and unsuppressed viral load
- Unstable housing is twice as common in those with IPV.

Thanks to

- SAC patients
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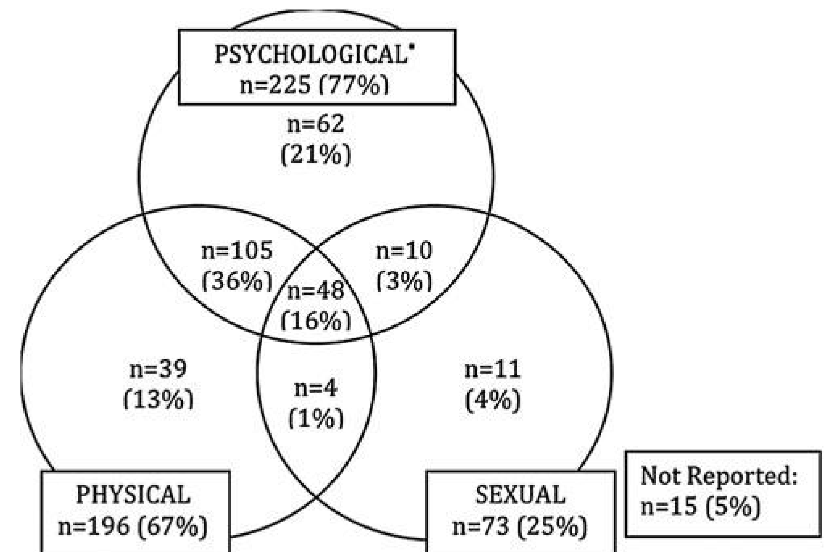
Types of IPV experienced

Among women:[1]

TABLE 1. Types of IPV Experienced (n = 137)

	n (%)
Type of abuse	
Emotional	107 (78.1)
Physical	107 (78.1)
Sexual	57 (41.6)
Intimidation	26 (19.0)
Financial	24 (17.5)
Isolation	21 (15.3)
Neglect	14 (10.2)
No. abuse types	
1	34 (24.8)
2	36 (26.3)
3	31 (22.6)
4	11 (8.0)
5	10 (7.3)
6	7 (5.1)
7	7 (5.1)
Not reported	5 (3.6)
Average (SD)	2.6 (1.6)

All patients:[2]



1. Siemieniuk RA, et al. J Acquir Immune Defic Syndr. 2013;64:32-8..
2. Siemieniuk RA, et al. AIDS Patient Care STDS. 2010;24:763-70