

2022

Intimate Partner Violence Education in an Outpatient Setting

Juddy Morgan
Walden University

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Walden University

College of Nursing

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Juddy Morgan

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University

2022

Abstract

Intimate Partner Violence Education in an Outpatient Setting

by

Juddy Carline Morgan

MS, Walden University, 2014

BS, Florida Atlantic University, 2010

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2022

Abstract

Intimate partner violence/domestic violence (IPV/DV) has been a widely recognized yet preventable public health concern. Despite the increased attention to IPV/DV, there has been a lack of knowledge in recognizing its symptoms and referring victims to appropriate community services by staff in a mental health outpatient clinic. The purpose of this project was to provide the clinic staff with the knowledge to recognize symptoms of IPV/DV victims and refer them to appropriate services within the community. The educational intervention was designed to increase the clinic staff's knowledge of recognizing victims of IPV/DV; becoming familiar with the Hurt, Insult, Threaten, Scream tool; and referring victims to appropriate community resources. The theory of planned behavior was used as a guide to accomplish the project goals. The clinic staff were given a 10-question pretest, then received a 30-minute PowerPoint presentation on recognizing IPV/DV victims and providing necessary care. At the end of the presentation, the clinic staff were given a 10-question posttest. The pretest data revealed that 5.5% of the clinic staff were able to recognize symptoms of victims of IPV/DV and 0% of victims were referred to community services. Posttest data revealed a 96.4% increase in the clinic staff's knowledge of IPV/DV, resulting in 68.9% of victims being referred to services within the community. Positive social change was evident at the project site as the stakeholders began using the project's educational information as part of their intake process.

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Dedication

Without the help of Almighty God, I would not have been able to accomplish this project. I would like to dedicate this project to my mother, husband, and daughters. This would not have been a thought without the resilience and determination instilled by my mom. I can still hear her voice: "Education is important, I was not able to get it so please put something in your head." Despite my mom not being able to see me complete this journey, I think about her every step of the way. I do not have the words to thank my husband and my daughters for their endless love, support, and sacrifice, giving of the time that should have been spent together. A special thanks to Courtney, my husband who pushed me many days when I was at the point of giving up. With the deepest gratitude, I dedicate this degree to my mom, husband, and daughters.

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Table of Contents

List of Tables	v
Section 1: Nature of the Project	1
Problem Statement	1
Purpose.....	3
Nature of the Doctoral Project	4
Significance.....	7
Summary	8
Section 2: Background and Context	10
Concepts, Models, and Theories.....	10
Relevance to Nursing Practice	12
Local Background and Context	14
Definition of Terms.....	16
Role of the DNP Student.....	17
Role of the Project Team	18
Summary	19
Section 3: Collection and Analysis of Evidence.....	20

Practice-Focused Question.....	21
Sources of Evidence.....	21
Evidence Generated for the Project	26
Participants.....	26
Procedures.....	27
Instruments.....	29
Validity	
29	
Reliability.....	30
Protection	30
Analysis and Synthesis	31
Summary.....	32
Section 4: Findings and Recommendations.....	33
Summary of Findings.....	34
Objective 1: Increase Clinic Staff Knowledge by 80% or Greater in Recognizing Victims of IPV/DV	34
Objective 2: Post Education the Clinic Staff Would Screen Victims and Refer to Appropriate Community Resources.....	36

Individuals.....	40
Institution	40
Recommendations.....	41
Contributions of the Doctoral Project Team.....	42
Strengths and Limitations of the Project.....	44
Strengths	44
Limitations	44
Summary	45
Section 5: Dissemination Plan	46
Analysis of Self.....	46
Practitioner	46
Scholar	47
Project Manager	47
Completion of the Project	48
Summary	49
References.....	50
Appendix A	58

Clinic Staff's Preparedness to Recognize IPV/DV Symptoms.....	58
Appendix B	62
PowerPoint Presentation	62
Appendix C	65
Poster and Handouts.....	65
Appendix D	70
HITS Hurt, Insult, Threaten, and Scream	70

List of Tables

Table 1 <i>Pretest</i>	35
Table 2 <i>Posttest</i>	36
Table 3 <i>Retrospective Data</i>	37
Table 4 <i>Prospective Data</i>	39

Section 1: Nature of the Project

In the United States, millions of individuals are affected by intimate partner violence/domestic violence (IPV/DV) each year. IPV/DV extends beyond physical injuries and can result in death (Centers for Disease Control and Prevention [CDC], 2020). In an outpatient mental health clinic setting, staff demonstrated a lack of knowledge in recognizing symptoms of IPV/DV. The project's objective was to educate clinic staff to become equipped in recognizing symptoms associated with victims of IPV/DV, using various educational tools such as handouts and a visual presentation. A pretest will be given followed by a posttest to evaluate the knowledge gained by staff. The staff would become familiarized with the Hurt, Insult, Threaten, Scream (HITS) instrument, an educational guideline used to recognize symptoms of IPV/DV, and would be shown how to effectively use the tool in everyday practice. As a result of this educational project, clinic staff were expected to increase their knowledge in recognizing victims of IPV/DV, which would not only significantly impact the lives of the victims, but it would also impact families and communities. Section 1 presents the problem statement, purpose, nature of the doctoral project, significance, and summary.

Problem Statement

IPV/DV is a widely recognized problem. IPV/DV is a preventable public health problem affecting millions of Americans, which can occur among same sex or heterosexual couples and consists of psychological, physical, or sexual harm by a current or former spouse or partner (CDC, 2018). Despite the increased attention to IPV/DV, one area of knowledge deficit for staff working in an outpatient mental health setting caring

for victims was the lack of knowledge in recognizing its symptoms, due in part to lack of appropriate training. In Maryland during 2016, 22 DV programs shared in collecting data on the services provided; there were 46 domestic violence related deaths, with 956 victims seen in one day (National Network to end Domestic Violence [NNEDV], 2019). Of the 956 victims, 407 sought refuge in transitional or emergency shelters by the local DV programs, and 549 adults and children received nonresidential services such as counseling, children's support groups, and legal advocacy (Government Office of Crime Control, 2018). The gap between the clinic staff's lack of knowledge in recognizing symptoms of IPV/DV and nursing practice could be unfavorable to the victims and families within the community.

At the doctor of nursing practice (DNP) project site, providers were seeing an increase in the number of IPV/DV referrals that were made by the Department of Social Services (DSS). Eighty-five percent of clients served by the practice site are referred by DSS, and of this number approximately 15% were referred for mental health services because of IPV/DV. On average, the clinic serves approximately 480 clients monthly, which means about 408 are referred by DSS and about 61 clients are referred because of IPV/DV. At the time of the project, the clinic staff lacked knowledge in identifying victims of IPV/DV because there was no formal education provided to clinic staff for recognizing symptoms of IPV/DV. Not only were the clinic staff lacking knowledge, but there was no standardized approach to screening and documenting, which was hindering victims from being referred to appropriate services within the community. Due to the negative impacts of IPV/DV, which include adverse mental health symptoms, it was

imperative that clinic staff be educated on recognizing symptoms of IPV/DV. In response, the project consisted of an educational program to provide clinic staff with the knowledge needed to recognize symptoms of IPV/DV to provide appropriate care to victims.

Purpose

IPV/DV is a major concern as seen by the number of individuals who are affected by the negative impacts. Studies have shown that nearly 1 in 4 women and 1 in 7 men have experienced severe physical violence from an intimate partner during their lifetime (CDC, 2020). IPV/DV victims suffer negative health outcomes including reproductive, cardiovascular, gastrointestinal, nervous system, musculoskeletal conditions along with mental health problems such as post-traumatic stress disorder and depression (SAMHSA, n.d.). Providing clinic staff with the knowledge to recognize symptoms of IPV/DV was intended to mitigate these negative effects.

The purpose of this project was to provide staff at the community mental health clinic with the knowledge and tools needed to recognize symptoms of victims of IPV/DV, to effectively provide care for them, and to refer them to appropriate community resources. IPV/DV continues to be a significant public health issue that incurs considerable societal costs (CDC, 2020). Of the female and male survivors, 41% of females and 14% of males experience some form of physical violence. According to U.S. crime reports, approximately 1 in 6 homicide victims are killed by an intimate partner (CDC, 2019). The purpose of this project was to reduce the gap in practice by providing staff with the education needed to recognize symptoms and appropriately care

for victims who would otherwise continue to encounter the negative effects of IPV/DV, which could result in death.

The practice-focused question for this DNP project was the following: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care? The purpose of the project was to reduce the gap between knowledge and practice by providing clinic staff with the education needed to recognize symptoms of victims of IPV/DV in an outpatient setting. As a result of the evidence-based education provided to clinic staff, they would be more equipped to recognize symptoms of IPV/DV and provide victims the care that is needed, thereby reducing negative impacts of IPV/DV.

Nature of the Doctoral Project

The databases that were used were EBSCOhost, ProQuest, CINAHL, Medline, CINAHL Plus, PubMed, Maryland.gov and Centers for Disease Prevention and Control. Search terms that were used included *intimate partner violence*, *domestic violence*, *HITS tool*, *intimate partner violence AND effects*, *domestic violence AND Maryland*, *intimate partner violence AND Maryland*, and *Maryland statistics AND intimate partner violence AND education for intimate partner violence*. Other sources of evidence that were used in providing education to the staff to identify symptoms of IPV/DV were policies and procedures from the practice site related to staff training. The literature search included articles published from 2014 to 2021. Exclusion criteria included literature not published in English and articles not related to IPV/DV.

A before-after design was used for the project. The first step was to have the office manager provide a de-identified list of patients who are referred by DSS because of IPV/DV, which I entered into an Excel spreadsheet. The information that was entered into the Excel spreadsheet included the number of clinic staff participating in the project, the number of referred victims of IPV/DV, and the type of care the patient received if referred for services. Referral sources included Futures without Violence, House of Ruth Maryland, Women's Law Center of Maryland, Inc., and Maryland Coalition Against Sexual Assault (Maryland Department of Health, n.d). The information gathered was stored on a secure, password-protected laptop used only by me and locked in a private office.

Clinic staff were given a pretest to assess their knowledge on identifying symptoms of IPV/DV during a monthly staff meeting. The pretest, entitled "Clinic Staff's Preparedness to Recognize IPV/DV Symptoms," was a brief assessment tool comprising 10 questions to be completed using paper and pencil. The test was given at the beginning of the staff meeting and took approximately 20 minutes to complete. The test was intended to assess the clinic staff's knowledge of IPV/DV, their ability to recognize symptoms of IPV/DV, the organization's policy regarding screening for IPV/DV, resources provided to victims, and staff training. The participants submitted the completed test in the envelope marked "IPV/DV Pretest," which was placed on a table at the front of the room. The office manager picked up the envelope containing the IPV/DV pretest from the table and kept it in a locked cabinet in a private office. The pretest results would be compared with the posttest results.

I delivered the PowerPoint presentation during the monthly staff meeting. The PowerPoint presentation lasted 30 minutes. The presentation provided a visual demonstration of using the HITS and an educational guideline on recognizing symptoms of IPV/DV. Educational handouts that were provided placed emphasis on the symptoms, behaviors, and risk factors of IPV/DV. Following the presentation, time was allotted for questions and answers. Once the presentation was completed, the posttest was administered.

The posttest consisted of the same questions given in the pretest. Staff were allotted the same amount of time to complete the posttest. The posttest was distributed by me after the educational presentation. The participants submitted the completed posttest in the envelope marked "IPV/DV Posttest," which was placed on a table at the front of the room. The office manager picked up the envelope containing the IPV/DV posttest from the table and kept it in a locked cabinet in a private office. The pretest results were compared with the posttest results. To determine the staff's ability to identify symptoms of victims of IPV/DV, I compared the percentage of correct responses on the pre- and posttests.

The anticipated findings and the gap in practice would be identified by reviewing the number of clinic staff who increased their knowledge of identifying symptoms of victims of IPV/DV based on the scores documented by the clinic staff from the educational guideline, which consisted of clinic staff being able to identify symptoms of IPV/DV. The de-identified reports of the list of patients who were referred by DSS because of IPV/DV were provided to me biweekly by the office manager and were stored

on a password-secured computer in a locked office. I requested the referral information over an 8-week period from the officer manager to compare the pretest data and the posttest data.

Significance

The purpose of the project was to equip clinic staff with knowledge to recognize symptoms of IPV/DV so staff could provide victims with appropriate care and empower victims, which would result in a decrease in the negative impacts of IPV/DV. Key stakeholders who would be impacted were providers, therapists, and counselors because they would play an important role in the success of the project. They were informed of the objective of the project and the role they would play in its implementation. I did not anticipate that there would be any hesitation because they provide care for victims of IPV/DV. Case management were involved because this team handles the discharge of patients when a higher level of care is needed. Another key stakeholder was the office manager, who would access and provide information from patients' records. Other key stakeholders included the ancillary staff who play an integral role in registering patients for their appointments. The collaboration among the teams would allow for clarification, which would eliminate any reluctance.

Potential contribution to nursing practice includes providing education to clinic staff through health promotion frameworks. As a DNP nurse practitioner, I can provide the facts relating to IPV/DV, the possible negative impacts associated with IPV/DV, the urgency to be able to recognize the symptoms of victims, and the importance of being able to knowledgeably care for victims. Other outpatient clinics who may be

experiencing similar practice issues may use the evidence-based findings to make changes within their practices.

In addition to the devastating consequences to victims, there are considerable costs to society that are associated with mental health services, medical services for IPV/DV related injuries, childcare, lost productivity from paid work, criminal justice services, child welfare costs, and household chores (CDC, 2019). Positive social changes may be accomplished by means of education that would reduce the negatives effects of IPV/DV. By educating staff to identify symptoms of IPV/DV and referring the patients to the appropriate services within the community, this project may benefit not only victims but also society in general. Victims of IPV/DV may avoid the devastating effects such as depression, post-traumatic stress disorder, and reproductive health issues. In addition, the costs to society in providing mental health services, medical services, criminal justice, and childcare services may be lessened.

Summary

IPV/DV is a persistent public health problem despite increased attention, and the negative impacts can be devastating. The goal of this project was to provide educational information to clinic staff, including using the HITS instrument to assist staff in recognizing victims of IPV/DV in the outpatient setting. I anticipated that the education would better equip clinic staff to recognize the symptoms associated with IPV/DV and refer victims to appropriate community resources, thereby increasing the number of victims who receive appropriate care. A before-after design was used to assess the knowledge gained from the educational intervention and the process of using the HITS

instrument. The goal of this project was to effect positive social change that would impact the community as evidenced by the reduction of the distressing effects such as depression, post-traumatic stress disorder, and reproductive health issues experienced by victims of IPV/DV. Section 2 presents the background and context for the project by highlighting concepts, models and theories, relevance to nursing practice, local background and context, and the role of the DNP student in implementing the project.

Section 2: Background and Context

IPV/DV is a serious problem with lasting harmful effects. The purpose of this project was to increase clinic staff's knowledge in recognizing victims of IPV/DV and referring them to appropriate community resources to reduce the devastating effects that victims experience. Given clinic staff's lack of knowledge in recognizing symptoms of IPV/DV, the goal of this project was to equip staff with knowledge to identify symptoms of IPV/DV. The practice-focused question was the following: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care? Section 2 includes a discussion of the concepts, models, and theories supporting the practice change; the relevance to nursing practice; the local background and context; and the role of the DNP student.

Concepts, Models, and Theories

The theory that was used to support the project was the theory of planned behavior (TPB) developed by Ajzen (1991, as cited in Asare, 2015) to predict human behavior. TPB suggests that an attitude toward behavior, subjective norms, and perceived behavioral control influence behavioral intention (Asare, 2015). Behavioral intention is the motivational aspects influencing the behavior; the stronger the intention to engage in the behavior, the more likely it is the person will perform it (Asare, 2015). Attitude toward the behavior is the extent to which an individual has a favorable or unfavorable assessment of the behavior, consisting of behavioral beliefs and outcome evaluations

(Asare, 2015). Subjective norms, the third component, include the social pressure to perform or not to perform the given behavior (Asare, 2015).

The first principle of TPB was used to address the attitude of the staff as determined by their beliefs about performing the behavior. A survey asking clinic staff about their willingness to participate in the educational program to recognize victims of IPV/DV and referring them to resources within the community was used to evaluate their attitude. Attitudes can motivate an individual to engage in a behavior they feel capable of performing. Similarly, attitudes of health care professionals can facilitate behaviors due to a belief that performing the behavior will result in desired outcomes (Zorjan et al., 2017). The second principle of TPB, that behavioral intention can influence the behavior, was used to examine the intentions of the clinic staff to engage in the behavior by asking them whether they believe they are capable of recognizing victims of IPV/DV to refer them to appropriate resources. The educational training would provide the knowledge and tools to equip clinic staff in recognizing symptoms of IPV/DV and would remove any barriers they may experience in doing so, thereby allowing them to take control of their behaviors and intentions and incorporate the knowledge gained in daily practice. The third principle of TPB, subjective norms, is the social pressure to perform or not to perform the given behavior. This principle was used to assess the clinic staff by asking them how likely their superiors would approve of them being educated to recognize victims of IPV/DV. I anticipated that approval from their supervisors would encourage the clinic staff to agree to adopt the IPV/DV education as a standard within their practice. The TPB supported my recommendation to educate the clinic staff for them to recognize

victims of IPV/DV. TPB was used to highlight clinic staff's attitudes in taking action to care for victims of IPV/DV, which would reduce the negative impacts within their communities.

Research has shown that TPB has been effective in predicting intentions and behaviors (Asare, 2015). Kiene et al. (2014) used the TPB as a framework to determine behavior toward contraceptive use to prevent pregnancy. The result revealed that the model was a good fit because the measured contraceptive use behavior indicated an increase in the degree of behavioral commitment. Asare (2015) used the TPB to determine condom use behaviors in college students and found that the participants attitudes toward condom use substantially predicted their intentions to use condoms. In the current project, the TPB was used to determine whether there was a change in the clinic staff's attitudes and intentions to recognize the symptoms of victims of IPV/DV and refer them to appropriate services after the educational training. The training would provide the knowledge and tools to equip the clinic staff in recognizing symptoms of IPV/DV and would remove any barriers they may experience in doing so, thereby allowing them to take control of their behaviors and incorporate the knowledge gained in daily practice.

Relevance to Nursing Practice

IPV/DV continues to be a serious public health issue in the United States as millions of Americans are affected each year (CDC, 2015b). Despite efforts to address IPV/DV, it has been recognized as a major unreported public and social problem. Health

care professionals play an important role in the recognition of IPV/DV, yet many are not equipped with the education needed to recognize its symptoms to reduce the negative impacts of IPV/DV to reduce further violence (Leppäkoski et al., 2014).

Recommendations to educate and train health care providers (HCPs) are important to improve their approach to the patient demonstrating symptoms of IPV/DV (Leppäkoski et al., 2014).

At the time of the project, the clinic staff lacked knowledge in identifying victims of IPV/DV, resulting in lack of referrals to appropriate services due to a lack of education, thereby reflecting a gap in practice. A recent study showed that nurses lack adequate knowledge to deal with victims of IPV/DV due to lack of training and educational experience (Alshammari et al., 2018). Sawyer et al. (2016) found that within numerous organizations there is an increased need for education for health care practitioners who encounter IPV/DV victims. The current evidence-based project would address the lack of education and training by educating clinic staff and increasing their knowledge in identifying symptoms of victims of IPV/DV and in referring them to community services to create better patient outcomes. A strategy to help educate the clinic staff is saturation training (Hamberger et al., 2015). Saturation training has been successful in addressing IPV/DV in training staff working within a particular clinic. The model increases staff awareness of IPV/DV and sensitivity to the needs of the victims. Saturation training sends an important message that the issue belongs to the entire system, not only frontline providers in the clinic (Hamberger et al., 2015). The DNP project addressed the gap in practice by providing standardized education to clinic staff to

equip them to identify symptoms of victims of IPV/DV and make appropriate referrals to community services.

Local Background and Context

In 2010, 4.23 million women and 2.97 million men reported being a victim of IPV/DV, and 18 women and 3 men were murdered because of IPV/DV in Maryland (Maryland.gov, n.d.). In 2014, there were 15,055 crimes reported to law enforcement agencies due to IPV/DV. Nationally, Maryland had the sixth highest lifetime rate of IPV/DV among females (Maryland.gov, n.d.). At the site for this project, 85% of clients served are referred by DSS, and of this number approximately 15% are referred for mental health services because of IPV/DV (Office Manager, personal communication, April 10, 2019). On average, the clinic serves approximately 480 clients monthly, which means that approximately 408 are referred by DSS and 61 are referred because of IPV/DV. As the population served continues to increase, so will the number of IPV/DV victims, which will increase the need for clinic staff to recognize symptoms of IPV/DV and refer victims to community resources. As a result of this project, IPV/DV victims may be referred to resources sooner, thereby reducing the devastating effects of IPV/DV.

The clinic provides services to the underserved populations who are of a lower socioeconomic status. The clinic works closely with DSS to recognize victims of IPV/DV as the clinic continues to provide comprehensive integrated care for the underserved throughout the state of Maryland (Office Manager, personal communication, April 10, 2019). The clinic provides services to children, adolescents, and adults of whom approximately 15% are victims of IPV/DV. The clinic's mission is to use technology to

provide clients with the most efficient and accessible care because everyone deserves access to mental health care regardless of socioeconomic status. Many individuals in this underserved area lack transportation, so to assist as many as possible to have access to mental health care the clinic provides transportation with no cost to those who do not own a vehicle (Office Manager, personal communication, April 10, 2019). At the time of the project, there was no standardized training for clinic staff to address the needs of victims of IPV/DV. The purpose of this project was to provide staff with the knowledge and tools needed to recognize symptoms of victims of IPV/DV, which would lead to an increase in the number of victims who are referred to appropriate community resources over a 6–8-week period. The project aligned with the clinic’s vision to provide education to staff to provide the best care to clients, thereby improving the quality of care and outcomes within the community.

To continue its mission of providing access to care regardless of socioeconomic status, the clinic partnered with Organization A to provide mental health services to 20 student athletes within the community at no costs to the participants. The participants who lacked knowledge of mental illness were educated on the topic and the stigma relating to it. Also, the clinic partnered with Organization B to hold conferences in which the proceeds were used to support access to therapy for low-income families in the community (Office Manager, personal communication, April 10, 2019).

Definition of Terms

Intimate partner violence/domestic violence (IPV/DV): Abuse within the context of an intimate partner relationship that include psychological, sexual, and physical abuse, as well as economic coercion (Office of Victims of Crime, 2018).

The National Intimate Partner and Sexual Violence Survey established a mechanism for ongoing public surveillance to provide national and state level data on IPV/DV (CDC, 2015a). The purpose of the public surveillance is to direct public action to reduce the mortality and morbidity related to IPV/DV and improve overall health (CDC, 2015b). When compared with other states, Maryland has a high rate of IPV/DV (Maryland.gov, n.d.). In 2014, law enforcement agencies reported over 15,055 crimes in Maryland that resulted from IPV (Maryland.gov, n.d.). Maryland has implemented several laws to protect victims of IPV/DV. For example, Bill SB 578/HB 167 was passed in 2016 to expand the eligibility for a domestic violence protective order, and Bill SB 1047 established a task force to study the recordings deeds of victims of domestic violence and make recommendations on protecting their identities and addresses (Maryland Department of Health, n.d.). In addition, the CDC has responded by providing numerous education brochures and training programs to reduce the risk of IPV/DV, demonstrating the need for education and training concerning IPV/DV (Maryland.gov, n.d.), which aligned with the DNP project to educate clinic staff to recognize victims of IPV/DV and refer them for services.

Role of the DNP Student

I am a psychiatric mental health nurse practitioner who, prior to becoming board certified, worked in mental health for more than 2 years. While employed at the local outpatient mental health clinic, I recognized that there was a need to respond to the needs of victims of IPV/DV due to the lack of knowledge of the clinic staff in caring for IPV/DV victims and referring them to appropriate services. I determined the need to work on this project, which would benefit the clinic, when I was given the opportunity to work in the field prior to becoming board certified. My role in this project was to develop the content that would be used to educate the clinic staff. I made myself readily available to staff to address their concerns. As a leader, my role was to collaborate with psychiatrists, nurse practitioners, administrative staff, and ancillary staff as the project progressed. Research has shown that collaboration improves patient outcomes (Bosch & Mansell, 2015).

In addition, my role was gathering the data on the number of victims of IPV/DV who had been referred for mental health services and whether any were referred for appropriate services over a 30-day period prior to implementing the project. Once the staff received the education, data would be collected over a 30-day period to evaluate staff knowledge of IPV/DV and victims' referral to services within the community. Once the project was completed, it was my responsibility to update the team of the outcomes, which would help to support implementing the change. When information is provided to the team, it increases the group's desire to make changes (Gesme & Wiseman, 2010).

My motivation to complete this project was to improve the care provided to victims of IPV/DV within the community. In addition, I was motivated to develop this project because a very close friend of mine had been a victim of IPV/DV; luckily, she survived her injuries. Research has shown that regardless of ethnicity, race, or socioeconomic status, women are more likely than men to be injured or killed by violence (Karakurt et al., 2014). Other physical and mental health effects of IPV/DV are gastrointestinal and gynecological problems, chronic pain, post-traumatic stress disorder, and depression. Many women experience violence during pregnancy resulting in harm to them and their children (Karakurt et al., 2014). My goal was to educate clinic staff to equip them to recognize symptoms of victims of IPV/DV so staff could provide care for victims and refer them to appropriate community resources.

Role of the Project Team

The project team included the office manager, clinical providers, therapists, social workers, and ancillary clinic staff. The office manager was provided de-identified data from patients' medical records regarding victims of IPV/DV who were referred to the clinic. The office manager scheduled the meetings for the team to discuss whether any victims were referred to community services. The clinical providers provided information based on their encounters with IPV/DV victims and their use of evidence-based data that would yield the best results. The therapists and social workers provided information related to the community resources that victims of IPV/DV could benefit from. The ancillary staff provided information on encounters with victims and any observations regarding victims' behaviors. The team had a strong desire to improve the quality of care

given to victims of IPV/DV within the communities served. The psychiatrist and nurse practitioners made recommendations on how the education could be standardized to recognize victims of IPV/DV and refer them for services.

Summary

The goal of the project was to reduce the gap between knowledge and practice by providing clinic staff with the education needed to recognize symptoms of victims of IPV/DV in an outpatient setting. By using the TPB as a framework to create an educational program, I was able to effect social change in recognizing victims displaying symptoms of IPV/DV. The DNP project was timely because, despite efforts to address IPV/DV, it continues to be unreported and millions of individuals are affected each year. Maryland ranks high in the rate of females who are victims of IPV/DV. My role in this project was to ensure that all identified gaps in practice were addressed and the barriers were either reduced or eliminated. The project team worked together to establish a standardization of care that would help to improve the quality of care within the communities. Section 3 includes the practice-focused question, sources of evidence, and analysis and synthesis of the data collected relating to the intervention to educate clinic staff to identify symptoms of IPV/DV to provide care to victims.

Section 3: Collection and Analysis of Evidence

There is growing evidence that violence is associated with detrimental effects on the mental and physical health of children, women, and men. IPV/DV is linked to adverse pregnancy outcomes such as preterm delivery, miscarriage/abortion, low birth weight, placental abruption, and perinatal death (D'Souza et al., 2018). Adverse behavioral risks and mental health consequences associated with IPV/DV include tobacco use, depression, anxiety disorders, post-traumatic stress disorder, poor maternal nutrition, alcohol and illicit drug use, and suicide attempts (CDC, 2019). In 2017, the cost related to IPV was \$9.3 billion (Institute for Women's Policy Research, 2012). Given the negative impacts of IPV/DV, it is imperative to address the issue (D'Souza et al., 2018). The expected outcome of this DNP project was that the clinic staff's knowledge would increase after receiving standardized education to recognize victims demonstrating symptoms of IPV/DV and, as a result, victims would be cared for appropriately by being referred to proper community resources. Because death from IPV/DV is not uncommon, increased knowledge in developing treatment plans for victims could result in diminished effects of IPV/DV (Tol et al., 2019). I used a quantitative design to identify the clinic staff's lack of knowledge in recognizing victims of IPV/DV and referring victims for community services. Data collection included pretest and posttest to assess the possible change clinic staff's knowledge. Application of findings may result in IPV/DV victims being better cared for, leading to more positive outcomes. Section 3 includes a discussion of the practice-focused question, sources of evidence, analysis and synthesis, and summary of the project.

Practice-Focused Question

Educating staff regarding IPV/DV is important to encourage proper care for victims. At the outpatient mental health clinic where the DNP project was implemented, the clinic staff lacked knowledge in recognizing symptoms displayed by victims of IPV/DV. Of the victims who received services by the clinic, not one was referred to community services for victims of IPV/DV. The gap in practice revealed that the clinic staff failed to provide victims of IPV/DV appropriate care due to a lack of knowledge in recognizing symptoms of victims of IPV/DV.

To improve patient outcomes and population health in the community, IPV/DV victims need to be aware of the negative impacts of violence. To reduce or eliminate these negative impacts, IPV/DV victims need to know the resources that are available to them in the community. The practice-focused question was the following: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care?

Sources of Evidence

To address the practice problem of the clinic staff's lack of knowledge recognizing patients displaying symptoms of IPV/DV, a literature search was conducted. The databases used were EBSCOhost, ProQuest, CINAHL, Medline, CINAHL Plus, PubMed, Agency for Healthcare Research and Quality, Government Office of Crime Control, Maryland Department of Health, Maryland.gov, Office of Victims of Crime,

Substance Abuse and Mental Health Services Administration, and Centers for Disease Prevention and Control. Search terms used included *intimate partner violence, domestic violence, Hurt, Insult, Threaten, Scream (HITS) tool, adverse effects of IPV/DV, public initiatives to address domestic violence, vulnerable period of IPV/DV, training for providers increase intimate partner violence intervention, collaboration in healthcare, intimate partner violence AND effects, domestic violence AND Maryland, intimate partner violence AND Maryland, and Maryland statistics AND intimate partner violence AND education for intimate partner violence*. The literature search included articles from 2015 to 2021. Other sources of evidence that were used in providing education to the staff to identify symptoms of IPV/DV were policies and procedures from the practice site related to staff training. Exclusion criteria included literature not published in English and articles not related to IPV/DV. The number of articles located was 155; however, only 36 of them were used to support the project after the completion of a literature review matrix.

Because the clinic staff's knowledge can affect the care of IPV/DV victims, it was important to assess the staff's knowledge and attitudes toward caring for victims to interrupt the cycle of violence and reduce the negative impacts within their communities. Kalra et al. (2017) assessed the effectiveness of training programs, the purpose of which was to enhance HCPs' response to and identification of IPV/DV against women. The systematic review of literature revealed that training and education of health care staff has led to better care and outcomes for IPV/DV survivors. In addition, training has led to cost savings and cost effectiveness from a societal point of view. Training providers

should be an integral component of interventions for IPV/DV (Kalra et al., 2017). Kalra et al.'s study aligned with the DNP project because it provided a framework showing how changes in clinic staff's knowledge and attitudes toward victims of IPV/DV can impact their well-being.

Taghizadeh et al. (2018) investigated the effectiveness of training problem-solving skills related to IPV/DV against pregnant women. The results of the randomized clinical trial indicated that teaching problem-solving skills may minimize the psychological types of IPV/DV against pregnant women. Through problem-solving skills, expectant mothers can learn how to deal with their husbands' psychological and physical violence. Skills such as assertiveness can help pregnant women reduce that sexual type of violence against them by being bold to say no to their partners.

Kalra et al. (2021) assessed the effectiveness of training programs that sought to improve HCPs' responses to and identification of IPV/DV against women when compared to no intervention or training. The findings showed that training HCPs on IPV/DV could be effective for results that are precursors for positive behavioral changes. The study revealed that training enhances knowledge and self-perceived readiness among HCPs to respond to women affected by IPV/DV. The results also indicated that training could enhance HCPs' responses, such as the utilization of safety planning, documentation, and identification of IPV/DV in the case histories of women. This study supported my project in that training would enhance the identification of IPV/DV among clinic staff and staff would be able to refer clients to appropriate services within the community.

Sprague et al. (2019) developed an educational program with the purpose of providing HCPs with the skills and knowledge required to identify and help women in the fracture clinic who experience IPV/DV. The results indicated that the program was acceptable and the training was valuable. The participants expressed a desire for extra education and recommended improvements, such as allowing more time for scheduling training and having specific sites for training to the program. Also, family physicians noted that the training they acquired increased their awareness of IPV/DV. They desired more education on IPV/DV and reported that the program was valuable to their daily practice. This study supported my project in that it showed how increasing providers' awareness of IPV/DV through education could make it easier for them to care for victims, interrupt the cycle of violence, and reduce the negative impacts in communities.

Hegarty et al. (2020) conducted a systematic qualitative meta-synthesis to determine readiness of HCPs to identify domestic abuse and violence. Hegarty et al. found that the personal belief systems of practitioners influenced their readiness to address domestic abuse and violence. The participants indicated that they required an increase in general abuse awareness, including dealing with IPV/DV more routinely in clinical settings. In addition, the participants discussed that readiness to solve domestic abuse and violence could be fully realized if HCPs' actions and intentions received adequate support from strong health systems. This study supported my project in that more training would increase general abuse awareness among providers. Therefore, it would be easier for them to deal with IPV/DV.

Fawole et al. (2019) conducted a study to collect information about the perceptions of IPV/DV victims on the importance of raising the topic at health care facilities. The researchers also wished to explore how the data obtained could support IPV/DV victims and whether medical students were supposed to be trained on problems associated with IPV/DV. The results indicated that IPV/DV victims supported the idea that women should selectively be screened by HCPs. Fawole et al. found that in health care settings, IPV/DV can be addressed through provider-based referrals and counseling. This study supported my project in that it acknowledged the importance of training future providers on the issue of IPV/DV. Obtaining the appropriate knowledge would enable medical students to help IPV/DV victims in the future.

Fisher et al. (2020) conducted a study to determine clinical staff training levels, confidence, self-perceived knowledge, clinical skills, and obstacles to working effectively with family violence. The participants, including allied health, nursing, and medical staff, indicated they had low levels of confidence and knowledge while dealing with family violence in the clinical practice. The results showed that the clinical staff did not know how to help when patients told them that they were facing family violence. This study supported my project because it highlighted the necessity for more in-depth training of clinical professionals about family violence.

Zachor et al. (2018) examined how provider communication skills' training affects the frequency of IPV/DV and assessment of reproductive coercion. The results indicated that participants who receive training for IPV/DV and reproductive coercion

reported increased provision of information concerning IPV/DV materials. The results also suggested that training of either type significantly enhanced providers' communication regarding reproductive coercion and IPV/DV. This study supported my project because it indicated that training providers would improve their communication about IPV/DV so they could help victims address the problem.

Evidence Generated for the Project

Participants

The participants in the mental health clinic had certifications in child and adult psychiatry and psychotherapy. The team comprised a psychiatrist, two nurse practitioners, an office manager, three front desk staff, two case managers, and the therapists and counselors. The participants who held licenses maintained their certifications through their respective licensing boards.

The participants were chosen because each interacts with IPV/DV victims at some point throughout their clinic visits. At the time of the project, the clinic staff lacked knowledge in recognizing symptoms of victims of IPV/DV. The purpose of this project was to provide staff at the community mental health clinic with the knowledge and tools needed to recognize symptoms of victims of IPV/DV, to effectively provide care them, and to refer them to appropriate community resources. As a result of the education, the anticipated outcome was that clinic staff would be able to identify symptoms of IPV/DV and better care for these victims.

Procedures

The data collection procedure commenced after obtaining institutional review board (11-30-21-0397773). and practicum site approval. Retrospective data were retrieved from the practicum site review charts by the office manager who provided me with a de-identified list of patients via an Excel spreadsheet. The data were kept on a password-secured laptop in a private office. The reflected the number of clients seen at the clinic, the number of victims of IPV/DV referred by the DSS, and the number of victims referred to community services over the 90 days prior to the education. The data were used to evaluate the prevalence of gender-based violence, the clinic staff's ability to identify victims of IPV/DV, and the number of patients referred to community services.

The pretest was a brief assessment tool comprising 10 multiple choice questions to be completed using paper and pencil (see Appendix A). The test was given at the beginning of the staff meeting and took approximately 20 minutes to complete. The test assessed the clinic staff's knowledge of IPV/DV, their ability to recognize signs/symptoms of IPV/DV, their ability to screen and document victims of IPV/DV, and their knowledge of available resources to refer victims within the community. The staff's understanding was rated on a scale from 1 to 5, (1 = *not at all*, 2 = *not well*, 3 = *neutral*, 4 = *well*, and 5 = *very well*). The participants submitted the completed test in the envelope marked "IPV/DV Pretest," which was placed on a table at the front of the room. The office manager picked up the envelope containing the pretests and kept it in a locked cabinet in a private office. The pretest data were entered into an Excel spreadsheet and stored on a password-secured computer in a private office.

The 30-minute PowerPoint presentation was developed and presented by me and was given at the staff meeting (see Appendix B). The presentation consisted of information regarding the associated behaviors of IPV/DV, prevalence of IPV/DV, its cost to society, risk factors of IPV/DV, signs/symptoms of IPV/DV, consequences of IPV/DV, screening for IPV/DV, and documenting and referring victims of IPV/DV to community resources. Handouts and peer-reviewed articles that placed emphasis on IPV/DV symptoms, behaviors, and risk factors; the cost of IPV/DV to society; and strategies to effectively mitigate the effects of IPV/DV were provided (see Appendix C). The participants were given 20 minutes for questions and answers at the end of the presentation. The HITS tool obtained from CDC website was applied to educate the clinical staff to identify victims of IPV/DV (see Appendix D).

The posttest was a brief assessment tool comprising 10 multiple choice questions (see Appendix A). The paper-and-pencil test was given at the end of the staff meeting and took approximately 20 minutes to complete. The participants submitted the completed posttest in the envelope marked "IPV/DV Posttest," which was placed on a table at the front of the room. The office manager picked up the envelope containing the IPV/DV posttest from the table and kept it in a locked cabinet in a private office. The posttest data were entered into an Excel spreadsheet and stored on a password-secured computer in a private office. The data would provide evidence of an increase in the clinic staff's knowledge in recognizing the symptoms of IPV/DV victims served by the clinic.

Prospective data collection commenced after the educational training. The office manager collected the reports from each provider of the patients seen and any referrals for services made at the end of each day. The de-identified data were provided as a computer-generated hard copy daily. The data reflected the number of clients seen at the clinic, the number of victims of IPV/DV referred by the DSS, and the number of victims referred to community services over 60 days. The pretest data were entered in an Excel spreadsheet and stored on a password-secured computer in a private office.

Instruments

The instrument that was used in educating clinic staff was the HITS tool adopted from the CDC website (see Appendix D). HITS has four screening questions that included the following: In the previous 12 months, how frequently did your spouse (a) hurt you physically, (b) talk down to or insult you, (c) use physical harm to threaten you, and (d) curse or scream at you (Fakhari et al., 2019). The participants answered each of the questions appearing on separate table lines using a 5-point frequency format: *frequently, never, fairly often, rarely, and sometimes*. Because the HITS screening tool has four items rated between 1 and 5, the score values were expected to vary from a minimum of 4 to a maximum of 20, with 10 or higher giving evidence of IPV/DV (see Fakhari et al., 2019).

Validity

To assess the validity of the HITS screening tool, I used the Cronbach Alpha and interclass correlation coefficient (ICC). Validity refers to how well the instrument

measures what it was intended for measuring (Taherdoost, 2016). According to Walton et al. (2017), the HITS screening tool has a strong content validity, construct validity, and percent agreement of 88.9% to 100%. Content validity is the extent to which the content in the tool can be generalized by examining if all items are represented (Taherdoost, 2016). Clarity, wordiness, overlapping response, appropriateness of the response, relationship to the problem, psychosocial, socioeconomic, and physical contents were measured by the Cronbach Alpha and the scores were as follows: 0.875, 0.789, 0.938, 0.875, 1, 0.979, 0.911, and 0.979 respectively. The obtained ICC value was 0.71, $p < 0.005$.

Reliability

Reliability refers to the consistency and dependability of the obtained results (Taherdoost, 2016). The internal consistency (IC) and inter-rater reliability of each construct in the screening tool were calculated using Cronbach's alpha. The IC for the constructs was between 0.80-1.00, $p < 0.001$, which indicates a strong consistency and an inter rate reliability of 0.71, $p < 0.001$ (Walton et al., 2017).

Protection

I completed and submitted the Walden IRB form A. De-identified retrospective and prospective data was used to maintain the privacy and anonymity of the patients (Cohen et al., 2018). The risk for participants in this project was minimal. Prospectively, the office manager provided the de-identified data, which was obtained from a report from each provider and included the number of clients seen at the clinic, the number of

victims of IPV/DV referred by DSS, and the number of victims referred to community services over the period of 30 days. The report was provided as a paper/hard copy, computer generated copy. I secured the pre and posttests in a locked cabinet in a private office not accessible to the public. The pre-and post-implementation data were entered into an Excel spreadsheet and stored on a password-secured computer kept in a private office. Maintaining confidentiality of the patients is essential in ensuring the data is not shared with third parties and data is secured (Cohen et al., 2018).

Analysis and Synthesis

I analyzed and synthesized the de-identified data and included the retrospective and prospective information obtained from a report from each provider of the patients seen and referrals made for services by the office manager. For the analysis of the data, I used an Excel spreadsheet. The comparison data reflected the number of clients seen in the clinic, the victims referred by DSS, and the number victims referred to services within the community for 90 days. After providing education to clinic staff about recognizing the symptoms of IPV/DV, a comparison of the correct response on the pre and posttests was conducted. A score of 80% on the posttest was an indication that an increase in staff knowledge in recognizing symptoms of IPV/DV is evident. Increased staff knowledge in recognizing symptoms of IPV/DV has a positive impact in recognizing IPV/DV victims and referring them to appropriate community services. Data visualization tools such as tables and graphs aid in interpreting and presenting the analysis results (Sadiku et al., 2019), which is the reason for including visualization tools in this project.

Summary

To review the pertinent literature, I conducted search using the following databases: Maryland Department of Health, CINAL, PubMed, SAMHSA, MEDLINE. Searching for literature using the aforementioned databases enabled me to review publications that show the adverse effects of IPV/DV on the victims' mental, health, and behavioral outcomes. An educational intervention was applied to enhance the knowledge of the clinical staff in identifying the IPV/DV victims and referring them to community service. A quantitative methodology was most appropriate for this project with a pre and post-intervention during data collection and a comparison of the data to assess whether the intervention improved clinic staff knowledge of recognizing symptoms of IPV/DV in order to refer victims to appropriate community services. Using Excel, descriptive statistics are provided in the project results section. The results are displayed in tables and graphs to aid in interpreting and presenting the findings. In section 4, I discuss the findings and recommendations of the project and the contributions of the doctoral project team.

Section 4: Findings and Recommendations

The clinic staff in the outpatient setting lacked knowledge in recognizing victims of IPV/DV because they lacked formal education, did not have a standardized tool for screening victims, and did not refer victims to the appropriate services within the community. At the practice site, approximately 85% of clients are referred by DSS, and of this number approximately 15% are referred for mental health services because of IPV/DV. On average, the clinic serves approximately 480 clients monthly, which means about 408 are referred by DSS and about 61 clients are referred because of IPV/DV. The gap in practice was that the clinic staff lacked knowledge in recognizing symptoms of IPV/DV, did not use a standardized screening tool, and did not refer victims to the appropriate community services. The practice-focused question was the following: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care? The purpose of this project was to provide staff at the community mental health clinic with the knowledge and tools needed to recognize symptoms of victims of IPV/DV to effectively provide care and refer victims to appropriate community resources. Following the educational intervention, the clinic staff knowledge demonstrated an increase in being able to recognize victims of IPV/DV, became familiar with the HITS tool and how to use it in daily practice, and became aware of community resources to refer victims. Section 4 presents the findings and implications, recommendations, contributions of the doctoral project team, and strengths and limitations of the project.

Summary of Findings

The goal of the project was to educate clinic staff on recognizing victims of IPV/DV and increasing their knowledge to better provide appropriate care to victims and refer them to appropriate community resources. IPV/DV is a serious problem that may extend beyond physical injuries, and may lead to death (CDC, 2020). This project was conducted to answer the following question: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care? My first objective was to educate clinic staff to increase their knowledge by 80% or greater in recognizing victims of IPV/DV. My second objective was to determine whether the clinic staff would use the knowledge to screen for IPV/DV victims and refer them to community resources after the education intervention.

Objective 1: Increase Clinic Staff Knowledge by 80% or Greater in Recognizing Victims of IPV/DV

I provided the educational intervention for the clinic staff during the monthly staff meeting on December 2, 2021. The educational program began with an assessment of the clinic staff's knowledge of victims of IPV/DV. Clinic staff ($N = 55$) received a pretest consisting of a 10-question pencil-and-paper questionnaire worth 10 points each for every question answered correctly. The staff were instructed to remain anonymous and not to put any names on the test. The completed pretests were collected by the office manager and placed in an envelope labeled "IPV/DV Pretest" and secured in a lock cabinet in a

private office. The pretest results showed that less than 6% of the clinic staff had knowledge of IPV/DV, which demonstrated a lack of knowledge in recognizing symptoms of victims of IPV/DV (see Table 1). The results indicated that the clinic staff needed educational intervention.

Table 1

Pretest

Staff scoring range	Total number of staff	Result
0–2	17	30.9%
3–5	21	38.1%
6–7	14	25.5%
8–10	3	5.5%
Total	55	100%

A 30-minute PowerPoint presentation was given immediately following the pretest, which addressed all components of the pretest. The educational presentation included the symptoms to look for when a victim arrives at the clinic, available community resources to refer victims, the HITS tool and how to use it, and education regarding how to prevent IPV/DV. Following the education, participants were allowed time to ask questions. The same test was administered as posttest (see Appendix A) to evaluate the knowledge gained. Upon completion, the posttests were collected by the office manager and placed in an envelope labeled “IPV/DV Posttest” and secured in a lock cabinet in a private office.

The posttest data were transcribed and entered into a Microsoft Excel spreadsheet and stored on a password-secured computer in a private office. The posttests were analyzed and compared to the pretests using descriptive statistics. The results of the posttest showed that approximately 96% of the clinic staff were able to recognize symptoms of victims of IPV/DV (see Table 2). The first objective provided evidence of an increase in the clinic staff knowledge in recognizing the symptoms of IPV/DV victims.

Table 2

Posttest

Staff scoring range	Total number of staff	Result
0–2	0	0%
3–5	0	0%
6–7	2	3.6%
8–10	53	96.4%
Total	55	100%

Objective 2: Post Education the Clinic Staff Would Screen Victims and Refer to Appropriate Community Resources

Retrospective data included the number of clients seen at the clinic, the number of victims of IPV/DV referred by DSS, and the number of victims referred to community services before the educational intervention. The de-identified data were obtained by the office manager from the reports given by each provider and were given to me as a paper

copy. The information provided by the office manager reflected 8 weeks of retrospective data of victims screened and referred for services and the number of victims referred by DSS. The data were uploaded into Excel spreadsheets and analyzed using descriptive statistics on a password secured laptop. The retrospective data (10, 04, 2021, to 11, 30, 2021) showed that none of the 125 clients referred by DSS in October and none of the 120 clients referred by DSS in November were screened or referred for services, demonstrating the staff's lack of knowledge in screening and referring victims for services (see Table 3).

Table 3

Retrospective Data

Category	October	November	Total	Percentage
Number of clients screened and referred to services	0	0	0	0
Number of clients not screened or referred for services	125	120	245	100
Number of referred IPV/DV victims	125	120	245	100

After the educational intervention, I expected that the clinic staff would screen victims and refer them to the appropriate community services. The clinic staff were provided handouts they could use as a reference and education they could provide to clients (see Appendix C). In addition, they were given a copy of the HITS tool to use in screening clients (see Appendix D). The information provided by the office manager

reflected 8 weeks of prospective data of victims screened and referred for services and the number of victims referred by DSS. The office manager provided the de-identified prospective data to me as a paper copy. The data reflected 8 weeks post educational intervention of the number of clients screened and the number of victims referred to community resources. The data were uploaded into an Excel spreadsheet and analyzed using descriptive statistics on a password-secured laptop. The prospective data for December (12, 02, 2021, to 12, 31, 2021) indicated that 730 clients were seen in the clinic, of which 85% were referred by DSS. Of this number, 16.9% were referred for mental health services because of IPV/DV. Of the 730 clients served, 620 were referred by DSS and 105 were referred because of IPV/DV. January's prospective data (01, 03, 2022, to 01, 31, 2022) indicated that 779 clients were seen in the clinic, of which 85% were referred by DSS. Of this number, 17.2% were referred for mental health services because of IPV/DV. Of the 779 clients served, 662 were referred by DSS and 114 were referred because of IPV/DV. The cumulative prospective data (12, 02, 21, to 03, 31, 2022) showed that 1,509 clients were seen in the clinic, of which 85% were referred by DSS. Of this number, 17.1% (average of 16.9% and 17.2%) were referred for mental health services because of IPV/DV. Of the 1,509 clients served, 1,282 were referred by DSS and 219 were referred because of IPV/DV. The prospective data showed that of the identified victims for the months of December and January, the clinic staff demonstrated knowledge of identifying symptoms of victims of IPV/DV and referred victims to community services. The intervention showed a 68.9% increase in screening and referring victims (see Table 4).

Table 4*Prospective Data*

Category	December 2021	January 2022	Total	Percentage
Number of clients screened and referred to services	68	83	151	68.9
Number of clients not screened or referred for services	37	31	68	31.1
Number of referred IPV/DV victims	105	114	219	100

I used a before-after design to determine whether the educational intervention would increase the clinic staff's knowledge in recognizing victims of IPV/DV, as well as screening and referring victims to appropriate resources within the community. The motivation for this project was the lack of screening of IPV/DV victims and referral to community resources. The intervention showed an increase in the number of victims screened and referred to services from 0% to 68.9%. The identified reason for lack of screening and referral was lack of education and training. Training and education of health care staff has led to better care and outcomes of IPV/DV survivors (Kalra et al., 2017). The current project findings revealed that education of the clinic staff was an excellent approach to increasing the clinic staff's knowledge of recognizing victims of IPV/DV so they could be referred to appropriate services.

Individuals

The clinic staff willingly participated in the educational session. The increase in knowledge allowed the clinic staff to better care for IPV/DV victims. The project changed the clinic staff's attitude and motivated them to engage in screening and referring IPV/DV victims to community resources, thereby resulting in the desired outcomes (see Zorjan et al., 2017). As a result of this educational project, patient care improved. One of the providers who started using the HITS tool mentioned that at future staff meetings she would continue to remind the staff how beneficial it is to use this tool in screening for victims (Nurse Practitioner, personal communication, January 5, 2022).

Institution

The project was conducted at an outpatient mental health clinic. Because the project demonstrated improvement in patient care, the project team decided that they would continue to work at using the educational intervention until the clinic staff were consistently screening all referred victims and all victims were being connected with community services. Management decided that the office manager would work with the clinic staff to standardize the screening and referral process, and would arrange providers on a rotating basis to address the topic at the monthly staff meetings (Senior Staff, personal communication, January 5, 2022). Sprague et al. (2019) showed that having an educational program and allowing time for scheduling training can prove to be valuable. The current project helped improve the knowledge of the clinic staff in recognizing symptoms of IPV/DV and also showed improvement in patient care.

Recommendations

The project included an evidence-based tool to provide information to the clinic staff, which increased the staff's knowledge and raised awareness of patients who experience IPV/DV. To bridge a gap in practice, Kalra et al. (2021) recommended training to enhance knowledge of health care providers. As a result of the training provided in the current project, the clinical coordinator instructed the therapists and social workers to continue using the DNP educational intervention by making the HITS tool a part of the intake paperwork, and for the clinical providers to offer each patient the educational handouts regarding IPV/DV (see Appendix C). One recommendation was to continue training and educating the clinic staff to enhance the care of identified victims of IPV/DV. The continued use of the educational intervention will lead to not only better care and better outcomes, but also to cost-effective and cost-saving training (see Fisher et al., 2020). The goal is to extend the project to other local outpatient clinics, and eventually to the county and state. Another recommendation is to make the training structured because one of the best types of training is structured training (see Peterson et al., 2018). Having the office manager arrange for the education and training during staff meetings and standardizing the screening process will help to achieve that structure. Structured training enhances health care providers' ability to respond to victims of IPV/DV as they assist in helping the victims to willingly implement change (Peterson et al., 2018).

The clinical coordinator informed me of the clinical providers' plan to use the DNP project information in the other outpatient clinics they work (personal

communication, February 3, 2022). The handouts were given to patients hoping that they would share the information with their families, friends, and communities. In addition, the DNP project can be used educate therapists and social workers who are in training to benefit from the project's information, which can prove valuable in daily practice (see Sprague et al., 2019).

Contributions of the Doctoral Project Team

The success of the project depended on the stakeholders involved in caring for victims of IPV/DV seen at the clinic. The office manager provided information regarding victims referred to the clinic. The clinical coordinator informed the staff during staff meetings of the project's progress and the changes that would be implemented as a result. The clinical providers, social workers, and therapist provided their feedback on the educational information that should be presented and what they thought would benefit the victims. The ancillary staff assisted the clinical providers, therapists, and social workers in ensuring that identified victims would receive appropriate referrals. Collaborating with the team was important to complete the project. Interprofessional collaboration is essential in health care and has been shown to improve patient outcomes (Bosch & Mansell, 2015). Though viewpoints varied, all stakeholders provided their input, which positively affected the care given to IPV/DV victims. The clinic staff were readily available to assist in any area necessary.

After receiving final approval, the clinical coordinator ensured that all the clinical providers, therapists, and social workers were present at the educational presentation. Upon completion of the presentation, the clinical coordinator committed to helping the

clinical providers, therapists, and social workers to not only use the knowledge gained in using the HITS tool to screen victims but also to refer them to appropriate community services. As the DNP project team leader, my role was to gather all the information and implement the evidence-based educational training. The office manager assisted in making copies of the educational handouts for distribution to the staff. I provided a 30-minute PowerPoint presentation to the clinic staff, which included evidence-based information obtained from the CDC (2018 and 2020) about the symptoms of IPV/DV victims, the HITS tool, and prevention of IPV/DV. The staff received educational material that they can use in their practice and information that they can give to IPV/DV victims. Everyone was very happy with the results of the project because the project will be in place until the staff achieve 100% compliance in screening and referring victims to appropriate services, improving the outcomes for victims and communities.

Healthcare professionals play an important role in contributing their knowledge to the healthcare industry. To successfully share their knowledge, healthcare professionals need continued education and training. With the increased understanding about how to recognize victims of IPV/DV and refer them to appropriate services, clinic staff contributed to improved patient outcomes, thus, demonstrating the importance of education and training (Leppäkoski et al., 2014). Currently, the clinical coordinator is planning to introduce the DNP project to other outpatient clinics within the city after implementation of the educational intervention at this site achieving 100% screening and referring victims to community services. Additionally, the expectation is to extend this project after securing the appropriate resources.

Strengths and Limitations of the Project

Strengths

One of the strengths of the project is the clinic staff's willingness to increase their knowledge and improve patient care. As Zorjan (2017) noted, attitudes can motivate an individual to engage in a behavior they feel capable of performing. As a result of the provided education, clinic staff felt comfortable assisting IPV/DV, resulting in desired outcomes. Another strength of the project was cost effectiveness. The education was provided without any cost to the clinic staff. The clinic staff was also provided with free resources adopted from CDC website that they can use to educate victims.

Limitations

A limitation of the project was the time needed to compile that pre and post data for the intervention. Because of time constraints, the postintervention data was collected over a period of 60 days. The current COVID-19 pandemic affected appointment attendance. This limitation may be avoided in the future by evaluating the project outcomes over a longer period of time or use the forecasting method to project likely outcomes.

As a result of this project, the outpatient clinic staff will continue to use the educational intervention. In addition, this project will be implemented in other outpatient clinics in the near future. The project site will continue to educate clinic staff and continue to collect data over the next six months to confirm the clinic staff's knowledge in screening and referring victims, thus, contributing to the improvement of patient outcomes. As Sadiku et al. (2019) noted, a benefit of using a before and after design is

the ability to determine the improvement and aiding in data visualization tools in presenting the results.

Summary

The goal of the project was to increase the clinic staff knowledge regarding recognizing symptoms of IPV/DV victims and making appropriate referral to community resources. The motivation for this project was the lack of screening of IPV/DV victims and referral to community resources. The intervention did show an increase in the number of victims screened and referred to services from 0% to 68.9%, demonstrating achieving the project's objectives. The retrospective and prospective data showed that the clinic staff increased their knowledge in recognizing victims of IPV/DV, which enabled them to screen and refer victims to appropriate services. Section 5 includes a discussion of my dissemination plan, analysis of self, and summary.

Section 5: Dissemination Plan

I presented the project findings to the project team composed of the clinical providers, therapists, social workers, and ancillary staff via visual aids at the monthly staff meeting. The clinical coordinator requested that the project's information be disseminated through educational presentations. The clinical coordinator is the designated person who will serve as the contact person for the evidence-based project. The clinical coordinator has developed an educational manual to use as a guide to assist the clinical providers who will be implementing the project (Clinical Coordinator, personal communication, February 3, 2022).

Other venues where the project can be implemented include any outpatient mental health clinic that serves victims of IPV/DV. The appropriate audience would be clinical providers, therapists, social workers, and ancillary staff in mental health outpatient clinics. Implementing the DNP project has proven to increase the clinic staff's knowledge of recognizing symptoms of victims of IPV/DV and referring them to appropriate community services. This project has been useful in screening, identifying, and referring IPV/DV victims to community services, thereby reducing the negative impacts of IPV/DV.

Analysis of Self

Practitioner

Never in my dreams did I imagine pursuing my DNP. As a psychiatric nurse practitioner, I understand the complications and hardships patients encounter when dealing with IPV/DV. I have a close friend who experienced IPV/DV, so working on this

project increased my insight to be of assistance not only to my friend but also to the patients I serve. Walden University provided me the skills to become a change agent influencing positive change in practice. IPV/DV has resulted in devastating consequences for victims resulting in considerable costs to society (CDC, 2019).

As a DNP-prepared nurse practitioner, I have been equipped me with the necessary skills to identify gaps in practice and how to use evidence to improve the quality of health care. Collaborating with other health care professionals is paramount in improving patient care (Bosch & Mansell, 2015). The project also gave me an opportunity to increase my knowledge of IPV/DV, which will benefit me in daily practice.

Scholar

As a DNP scholar, I am prepared to evaluate problems faced by patients and communities and provide clinical expertise to solve them. As part of the project team, I had the opportunity to impart a greater depth and breadth of IPV/DV knowledge. The goal of the project was achieved. The project helped me to gain valuable leadership skills and recognize that collaboration is important in nursing practice (see Bosch & Mansell, 2015).

Project Manager

Being a project manager came with many responsibilities to guide the project from start to finish. My responsibility as the program manager also involved making sure that there were minimal costs to participants. I chose to use the time allotted during the

staff meetings to accomplish the educational intervention because the clinic staff are present at the building for staff meetings. Walden University enabled me to develop good leadership skills to accomplish the goal of the project by means of saturation training. Saturation training sends a vital message that the entire team is involved in an issue, not only frontline providers (Hamberger et al., 2015). As a result, I was able to use the assistance of the office manager and clinical coordinator to communicate with the team.

As a project manager, I had to be flexible and ask for advice from the committee chair and my preceptor. I learned not only to identify gaps in practice but also how to address and either reduce or eliminate the gaps. This project allowed me to be an integral part of training staff to increase their knowledge and confidence (see Fisher et al., 2020). The privilege of being the project manager afforded the opportunity to experience the benefits of being a leader.

Completion of the Project

Completing this DNP project has increased my awareness of the work involved in helping victims of IPV/DV. Although it brought me considerable satisfaction, it also gave insight into the needs of patients affected by IPV/DV. The project revealed that regardless of the issues facing practices in health care, there is a wealth of information available to educate health care professionals to better care for patients and improve outcomes. It was very rewarding to see the eagerness of other health care professionals put forth effort in affecting the lives of those they serve.

Completing this project was not the easiest journey. There were many obstacles that came up that caused me to question whether I had made the right decision. I had to overcome being a caregiver of family members with serious health issues and coping with the death of loved ones. I gained a deeper understanding of myself and how my determination to complete the project will benefit others. As discussed by Moshontz and Hoyle (2021), persistent goal pursuit is resisting the urge to give up. By being persistent, I was able to overcome the obstacles to reach the finish line.

Summary

The purpose of the DNP project was to educate the clinic staff and answer the practice-focused question: Will an intervention to educate the clinic staff to identify symptoms of IPV/DV as compared to the current staffs' knowledge in providing care increase the number of clinic staff who are able to identify victims of IPV/DV to provide necessary care? After careful analysis of the retrospective and prospective data, the answer to the question was yes. The doctoral project has helped to reduce the gap in practice by educating the clinic staff regarding IPV/DV and helping them to screen victims and refer them to appropriate community services. I will continue to develop my leadership skills and look for opportunities to fulfill Walden University's mission of making a positive impact on social change.

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Appendix A

Clinic Staff's Preparedness to Recognize IPV/DV Symptoms

1. Which of the following is the most accurate definition of IPV/DV?
 - A. Violent or aggressive behavior within the home, typically involving the violent abuse of a spouse or partner
 - B. Behavior involving physical force intended to hurt, damage, or kill or someone or something
 - C. Abuse or aggression that occurs within a romantic relationship
 - D. All of the above

2. What are the risk factors associated with IPV/DV?
 - A. Older adult
 - B. Unhealthy relationships
 - C. Low income
 - D. Employment
 - E. B & C are correct

3. All of the following are symptoms of IPV/DV to look for when a victim arrives at the clinic except:
 - A. Chronic headaches

- B. Depression
 - C. Egotism
 - D. Both A& B are correct
4. The U.S. Department of Health and Human Services recommended screening for IPV/DV, what is the policies for screening for IPV/DV?
- A. Screen only if abuse is suspected
 - B. Screen during new patient visits
 - C. Screen only those referred by DSS
 - D. Screen at annual examinations
 - E. Both B & D are correct
5. What resources are available within the community to refer victims?
- A. House of Ruth
 - B. Futures Without Violence
 - C. Women's Law Center of Maryland
 - D. All of the above
 - E. None of the above
6. Based on the 2014 studies, what is the estimated lifetime cost of IPV/DV?

- A. \$130,000
 - B. \$103,000
 - C. \$13,000
 - D. \$33,000
7. What does the HITS acronym stand for?
- A. Hurt, insult, threat, scream
 - B. Hurt , integrate, treats, slam
 - C. Hit, insult, teach, scared
 - D. Hug, insult, test, search
8. Signs of IPV/DV include: (select all that apply)
- A. Injuries to the face or other parts of the body
 - B. Lack of financial support
 - C. Embarrassed to speak about the subject
 - D. Poverty
 - E. All of the above
9. What are some barriers that providers face in screening for IPV/DV?
- A. Discomfort with discussing the topic

- B. Lack of time
- C. Need for privacy
- D. None of the above
- E. A, B & C are correct

10. How can you help to prevent IPV/DV?

- A. Educate clinic staff and patients
- B. Teach health relationship skills
- C. Provide resources
- D. None of the above
- E. All of the above

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<https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

<http://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html#reference>

Appendix B

PowerPoint Presentation

Definition of IPV/DV and associated behaviors such as:

Physical violence

Psychological aggression

Stalking

Sexual violence (CDC, 2020)

Prevalence of IPV/DV

One in three women and one in ten men have experienced IPV (WHO, 2021).

Approximately 43 million women and 38 million men have experienced psychological aggression by an intimate partner in the world (CDC, 2020).

Cost of IPV/DV

Lifetimes estimated cost of IPV/DV in 2014 was \$103,767 per female and \$23,414 per male victim

The population economic burden was nearly \$3.6 trillion over a victim's lifetime based on 43 million U.S. adults with a history of IPV/DV (Peterson, et al., 2018)

Symptoms of IPV/DV

Signs of depression

Substance use

Mental health problems

New or recurrent STIs

Expression of fear when discussing family planning options (American college of obstetricians and gynecologists (ACOG), 2021).

Signs of IPV/DV

Physical abuse

Cruel Words

Threats

Lack of financial support (WHO, 2018)

Consequences of IPV/DV

Physical injuries - may include bruises, fractures, broken bones or teeth, head injuries, attempted strangulation and neck and back injuries (WHO, 2021).

Homicide and other mortality – Forty to seventy percent of female deaths are related to a violent relationship. Also, women who experience IPV/DV have a higher probability of committing suicide (WHO, 2021).

Screening and documentation

HITS tool (CDC, 2018)

Appropriate documentation should include detailed description of the abuse

Names on individuals who witnessed the abuse

Time and location of abuse

<https://health.maryland.gov/phpa/mch/Documents/IPV%20Guide%20for%20providers.January.pdf>

Referral Resources

Futures without Violence - [\(202\) 595-7382](tel:(202)595-7382)

House of Ruth Maryland - [\(410\) 889-0840](tel:(410)889-0840)

Women's Law Center of Maryland, Inc. - [\(410\) 321-8761](tel:(410)321-8761)

Maryland Coalition Against Sexual Assault - [\(301\) 328-7023](tel:(301)328-7023)

<https://phpa.health.maryland.gov/OIDPCS/CSTIP/Pages/Intimate-Partner-Violence.aspx>

Prevention of IPV/DV

Teach healthy and safe relationship skills

Create protective environments

Support survivors to lessen harm and increase safety (CDC, 2020)

Appendix C

Poster and Handouts

What is intimate partner violence?

Intimate partner violence (IPV) is abuse or aggression that occurs in a romantic relationship. "Intimate partner" refers to both current and former spouses and dating partners. IPV can vary in how often it happens and how severe it is. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years. IPV can include any of the following types of behavior:

- **Physical violence** is when a person hurts or tries to hurt a partner by hitting, kicking, or using another type of physical force.
- **Sexual violence** is forcing or attempting to force a partner to take part in a sex act, sexual touching, or a non-physical sexual event (e.g., sexting) when the partner does not or cannot consent.
- **Stalking** is a pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's own safety or the safety of someone close to the victim.
- **Psychological aggression** is the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person.

IPV is connected to other forms of violence and is related to serious health issues and economic consequences. However, IPV and other forms of violence can be prevented.



Centers for Disease Control and Prevention. (2020). *Preventing intimate partner violence*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

How big is the problem?

IPV is common. It affects millions of people in the United States each year. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate:

- About 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.
- Over 43 million women and 38 million men have experienced psychological aggression by an intimate partner in their lifetime.

IPV starts early and continues throughout the lifespan. When IPV occurs in adolescence, it is called [teen dating violence](#) (TDV). TDV affects millions of U.S. teens each year. About 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before the age of 18.



Centers for Disease Control and Prevention. (2020). *Preventing intimate partner violence*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

How can we stop it before it starts?

- 
Teach safe and healthy relationship skills
 - Social-emotional learning programs for youth
 - Healthy relationship programs for couples
- 
Engage Influential adults and peers
 - Men and boys as allies in prevention
 - Bystander empowerment and education
 - Family-based programs
- 
Disrupt the developmental pathways toward partner violence
 - Early childhood home visitation
 - Preschool enrichment with family engagement
 - Parenting skill and family relationship programs
 - Treatment for at-risk children, youth, and families
- 
Create protective environments
 - Improve school climate and safety
 - Improve organizational policies and workplace climate
 - Modify the physical and social environments of neighborhoods
- 
Strengthen economic supports for families
 - Strengthen household financial security
 - Strengthen work-family supports
- 
Support survivors to increase safety and lessen harms
 - Victim-centered services
 - Housing programs
 - First responder and civil legal protections
 - Patient-centered approaches
 - Treatment and support for survivors of IPV, including teen dating violence

Centers for Disease Control and Prevention. (2020). *Preventing intimate partner violence*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

SPEAK UP TO END THE CYCLE OF HURT.

STOP INTIMATE PARTNER/DOMESTIC VIOLENCE

Definition of IPV/DV

Abuse or aggression that occurs in a romantic relationship (CDC, 2020)

RISK FACTORS:

**LOW INCOME, YOUNG AGE,
UNEMPLOYMENT, ECONOMIC
STRESS, POVERTY, UNHEALTHY
FAMILY RELATIONSHIPS
(CDC, 2020)**

**CENTERS FOR DISEASE CONTROL AND PREVENTION
(CDC). (2020). VIOLENCE PREVENTION. RETRIEVED FROM
[HTTPS://WWW.CDC.GOV/VIOLENCEPREVENTION/INTIMATEPARTNERVIOLENCE/RISKPROTECTIVEFACTORS.HTML](https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html)**

INTIMATE PARTNER/ DOMESTIC VIOLENCE

Signs & Symptoms of IPV/DV
Lack of financial support
Physical abuse
Cruel Words
Threats
Controlling you
Spying on you
Blaming you

HELP

Referral Sources:
Futures without Violence - (202) 595-7382
House of Ruth Maryland - (410) 889-0840
Women's Law Center of Maryland, Inc. - (410) 321-8761
Maryland Coalition Against Sexual Assault - 301-328-7023

Appendix D

HITS Hurt, Insult, Threaten, and Scream

How often does your partner physically Hurt you?

How often does your partner Insult or talk down to you?

How often does your partner Threaten you with physical harm?

How often does you partner Scream or curse at you?

Administration method: Self report or clinician administered. Scoring procedures: Each question is answered on a 5-point scale: 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently. The scores range from 4 to a maximum of 20. For female patients, A HITS cut off score 10 or greater was used to classify participants as victimized; for male patients, A HITS cut off score of 11 or greater was used to classify participants as victims of IPV/DV.

Centers for Disease Control and Prevention. (2020). *Preventing intimate partner violence*. <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>