UCSF Women's HIV Program – Screening Protocol

Screening Protocol for IPV and Consequences of Past Trauma

Purpose: To screen for Intimate Partner Violence (IPV) and consequences of past trauma including depression, anxiety, suicidality, Post-Traumatic Stress Disorder (PTSD), Alcohol and other Substance Use

Describe the clinical need for the protocol: This protocol will facilitate a timely and efficient process for primary care providers to screen and assess for IPV and consequences of past trauma. It will promote a thoughtful and consistent process.

Describe the criteria for execution of the protocol: a) a prompt to remind providers to do the screening every 6 or 12 months**,** b) instructions about conducting the screen (i.e. ensuring privacy), an opening script, and response instructions/script.

Screening Tools:

1. IPV: Questions adapted from different tools (every 6 months)
2. Consequences of past trauma (annually):
    - Depression: PHQ-2 plus suicidality question
    - Anxiety: GAD-2
    - PTSD: PC PTSD 5
    - Alcohol and other Substance Use: AUDIT-C, Questions from NIDA-Modified ASSIST, CAGE-AID

IPV Protocol:

Social work screens new patients at intake

Medical provider screens existing patients every 6 months and as needed

Protocol for positive-screen:

- Provider gets best contact information for patient and checks for injuries (makes report as needed)
- Provider gives warm hand-off to social worker at end of medical visit (with patients permission)
- Social worker meets with patient for further assessment, does lethality assessment, safety plan, calls Women Inc. or Casa de las Madres to link to IPV services and IPV shelter (if patient wants referral)
- If patient refuses to meet with social worker, provider will be trained to do safety plan with patient.

Follow-up to positive-screen:

- Provider schedules a follow-up visit within one month (within 1 to 2 weeks if patient refuses to meet with the social worker).
- Social worker continues to work with patient to connect to services/shelter, maintains weekly contact post-crisis for 8 weeks or more as needed.
- Patient is on Extra Attention (EA) list until they've been clear of IPV for 6 months

Training needed:

- Using safety card and conducting screening for providers and psychosocial team.
- Training on lethality assessment for psychosocial team.
- Women Inc. or La Casa de las Madres in-service training for all staff.

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Consequences of Past Trauma Protocol:

Social work screens new patients at intake

Medical provider screens existing patients annually and as needed

Protocol for positive-screen:

- If patient has suicidal ideation, provider or social worker would do an immediate full suicide risk assessment, safety planning, and/or initiate hospitalization as needed.
- If no suicidal ideation, provider makes referral to psychosocial team.
- In psychosocial team meeting, team reviews screens and what provider has shared about patient (and any other information known about patients history of treatment, etc.), and identifies what services might be most helpful for the patient and who will discuss the options with the patient
- Identified team member then contacts patient, discusses options, and initiates treatment.

Follow-up to positive-screen:

- Provider schedules a follow-up visit within one month (within 1 to 2 weeks if patient refuses to meet with the social worker and/or has suicidal ideation).
- Psychosocial team continues to support and consults with provider. Patient that is in treatment at WHP will be tracked by psychosocial staff who is providing treatment.
- Social workers will track patients who are receiving outside treatment and have ongoing contact with the treatment providers

Training Needed:

- Conducting screenings, suicide risk assessments, and safety planning.

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Screening Measures

1. **IPV: Questions from multiple sources**
   Opening Script: "*We have started talking to all our patients about how stress and abuse in relationships can affect your health. I'd like to share this safety card with you so you can know how to get help or can help others if a relationship becomes harmful…. (After reviewing safety card)…Would you mind me asking you a few questions about stress in your relationships?"*

IPV		no	yes	Prefer not to answer
1.	Does your partner control where you go, who you talk to, or how you spend money?	0	2	
2.	Are you ever afraid of your partner?	0	2	
3.	Does your partner scream at you, insult you or put you down?	0	2	
4.	Has your partner (or anyone else) hurt, hit, or threatened you? Within the last 12 months? Past?	 0 0	 2 1	
5.	Has your partner (or anyone else) forced you to have sex or do something sexual you did not want to do? Within the last 12 months? Past?	 0 0	 2 1	
6.	Has your partner (of anyone else) tried to force you to get pregnant or interfered with your birth control? Within the last 12 months? Past?	 0 0	 2 1	

Score of ≥ 2 refer to Social Services for more detailed assessment and safety planning as needed.

Response To Positive Screen: "*I appreciate you sharing this information with me, and I am sorry that this is happening to you in your relationship. I would like to have you meet with one of our social workers, so they can talk to you about ways to stay safe, protect yourself, and access resources that can help you do this. Would you be willing to let me connect you to one of them right now?"*

Response To Negative Screen: "*I appreciate you sharing this information with me. Please know that you that you can always talk to me or one of our clinic social workers if stress or abuse ever occurs in a relationship. We can provide you with support and resources."*

2. Consequences of Past Trauma

Opening Script: "*Stressful life experiences and pasts traumas can have a big impact on our physical and emotional health. We are asking **all** of our patients about some of the common symptoms related to these stressful events that can negatively impact your health and make it hard to take care of your health. Some of the symptoms I'll be asking you about are related to anxiety, depression, and substance use because they are commonly associated with trauma. These symptoms are normal reactions to trauma, and the information you provide will help us understand your health and develop a better treatment plan to address your health concerns. You do not have to answer any question that you do not want to answer."*

GAD-2, PHQ-2, and Suicidality

GAD-2	Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3

Score ≥ 3, refer to social work for fuller assessment including GAD-7

PHQ-2	Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3

Score ≥ 3, refer to social work for fuller assessment including PHQ-9

Suicidality Question	Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	not at all	several days	more than half the days	nearly every day
1.	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Score of ≥ 1 on suicidal ideation requires full suicide assessment to be completed by provider or social worker **immediately**

PTSD: Adapted Primary Care PTSD Screen for DSM 5 (PC-PTSD-5)

PTSD	In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the **past month**, you:	no	yes
1.	Have had nightmares about it or thought about it when you did not want to?	0	1
2.	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	0	1
3.	Were constantly on guard, watchful, or easily startled?	0	1
4.	Felt numb or detached from others, activities, or your surroundings?	0	1
5.	Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	0	1

Scores ≥ 3 refer to social work for fuller assessment including PCL 5

Alcohol Use: AUDIT-C Question and Modified ASSIST Question

Alcohol Use	Over the **past year**:	never	once or twice	monthly	weekly	daily or almost daily
1.	How often did you have a drink containing alcohol?	0	1	2	3	4

If "Never", stop here and proceed to Adapted NIDA Modified ASSIST

Alcohol Use	Over the past **year**:	never	once or twice	monthly	weekly	daily or almost daily
2.	How often did you have four or more drinks on one occasion?	0	1	2	3	4

Score = 3 on question 2, consider referral to social work for assessment (including full AUDIT) especially if person scores ≥ 1 on CAGE-AID
Score=4 refer to social work for assessment (including full AUDIT)

Other Substance Use: Adapted NIDA Modified ASSIST

Other Substance Use	Over the **past year**, how often have you used the following?	never	once or twice	monthly	weekly	daily or almost daily
1.	Tobacco Products	0	1	2	3	4
2.	Marijuana	0	1	2	3	4
3.	Prescription Drugs for non-medical reasons or not as prescribed:	0	1	2	3	4

4.	Other Drugs (i.e. cocaine/crack, heroin, methamphetamine)	0	1	2	3	4
If yes to prescription or other drugs, ask which substances/medications and how much they use? _____						

If "Never" for all substances, stop here.

Score of ≥ 3 on tobacco, provide education on harm caused by smoking and resources for quitting.

Score of ≥ 3 on marijuana, prescription drugs, and other drugs consider referral to social work for fuller assessment (including full NIDA Modified ASSIST) especially if person scores ≥ 1 on CAGE-AID

Possible Substance Use Disorder: CAGE-AID

Complete CAGE-AID if patient uses alcohol or other substances. If no use of alcohol or other substances, skip the CAGE-AID.

Possible Substance Use Disorder	In the last 3 months….	No	Yes
1.	Have you felt you should cut down or stop drinking or using drugs?	0	1
2.	Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	0	1
3.	Have you felt guilty or bad about how much you drink or use drugs?	0	1
4.	Have you been waking up wanting to have an alcoholic drink or use drugs?	0	1

Score ≥ 1, refer to social work for assessment.

Response To Positive Screen for Suicidality: Response To Positive Screen for Suicidality: "*I appreciate you sharing this information with me and I am sorry that you are having thoughts that you would be better off dead or of hurting yourself in some way. I'd like to talk to you a little bit more about this, because I want to help you stay safe." (Then conduct suicidality assessment).*

Response To Positive Screen (on any of the other measures): "*I appreciate you sharing this information with me, and I am sorry that you are experiencing….(list a couple of the symptoms they've endorsed during the screening). When any of my patients experience these types of symptoms, I like to connect them with one of our social workers who can further assess how you're doing and talk to you about available options for support. Would it be okay if I connect you with one of them right now?"*

Response To Negative Screen: "*I appreciate you sharing this information with me. Please know that you that you can talk to me or one of our clinic social workers if you have any of these experiences. We can provide you with support and resources."*