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Implementation of a Depression and Domestic Violence Screening Protocol in an Internal Medicine Setting

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Executive Summary

Introduction of the Problem

Depression is a prolific problem in the United States, with approximately 7.6% of Americans over age 12 reporting symptoms (Centers for Disease Control and Prevention, 2014). Socioeconomic status has a profound effect on depression, as those living below the poverty line have rates 2.5 times higher than those who live above the poverty line (Centers for Disease Control and Prevention, 2014). Though depression affects a vast number of individuals, only roughly 35% of sufferers actively seek professional help for their symptoms (Centers for Disease Control and Prevention, 2014). Much like depression, socioeconomic status is linked to incidences of domestic violence, as domestic violence rates were highest in low-income neighborhoods (Bonomi et al., 2014). Additionally, racial disparities influence incidences of domestic violence, as 43.7% of African American women, 37.1% of Hispanic women, and 34.6% of Caucasian women will experience some form of domestic violence in their lifetimes (Black et al., 2011).

The location in which this project was conducted was an internal medicine outpatient clinic in a small, industrial community in Southern Illinois. The residents of this community had a higher-than-average poverty rate when compared to county, state, and national averages. Before this project was conducted, there was no standardized process to screen for depression or domestic violence.

Literature Review

Socioeconomic status is widely correlated with depression, as those who live within a lower status are at higher risk for suffering from depression (Fan et al., 2011). Additionally, Fan et al. (2011) discovered higher rates of depression among people under 65 years old, African

Americans, women, those with lower educational attainment, those with lower incomes, and those with chronic health conditions. Similarly, Patel et al. (2018) found a statistically significant correlation between areas with larger levels of income inequality and higher rates of depression. These results are not unique in the United States, as German and Australian researchers reported similar correlations between lower socioeconomic status and rates of depression (Hoebel et al., 2017; Almeida et al., 2012).

Depression, much like other diseases and disorders, is most effectively managed when diagnosed and treated early. Bukh et al. (2013) suggest patients who forgo treatment for long durations have poorer outcomes from antidepressant interventions than those who seek treatment sooner. Patients who start antidepressant interventions within six months of onset had a 33.7% remission rate, while those who had symptoms for longer than six months before seeking intervention had a 21.1% remission rate once treatments were initiated (Bukh et al., 2013).

Like depression, domestic violence is also correlated to socioeconomic status. Bonomi et al. (2014) researched the factors linked to domestic violence incidences in nearly 6,000 couples and found the highest rates of domestic violence in neighborhoods with the lowest income. In addition to the immediate ramifications, 28.8% of women and 9.9% of men in the United States reported short and longer term impacts related to their abuse (Black et al., 2011). These impacts include, but are not limited to, experiencing injury, contracting a sexually transmitted infection, needing medical care, and needing legal or housing aid, among other impacts (Black et al., 2011).

Both depression and domestic violence are associated with societal stigmas which may prevent individuals from seeking help. For depression, African American adults especially reported negative attitudes toward seeking mental health treatment (Brown et al., 2010).

Additionally, relevant to domestic violence, several factors may influence an individual's likelihood of seeking help. For example, fear, emotional feelings for the abuser, cultural or religious influence, immigration status, and lack of financial independence may significantly influence a decision to report an incident or seek help (The National Domestic Violence Hotline, n.d.).

Project Methods

The aim of this project was to implement the use of two brief screening tools in an internal medicine setting to assess for risk of domestic violence as well as depression in patients who are being seen in the clinic. The entire staff, including the certified nurse practitioner, medical assistants, and other healthcare staff were educated and trained on both the Partner Violence Screening (PVS), which screens for domestic violence, and the Patient Health Questionnaire (PHQ-2) which screens for depression, and their use (Singh, Peterson, & Singh, 2014; El-Den et al., 2018). Both tools were widely described in the literature and were well validated among patients in the outpatient setting (Singh, Peterson, & Singh, 2014; El-Den et al., 2018).

Domestic violence rates are higher amongst those living in poverty, women who are pregnant, and those who live in areas of economic stress (Centers for Disease Control, 2018). Depression rates are higher among women, and among persons who have lower socioeconomic status. People who live below the poverty level were between two and three times more likely to have depression (Centers for Disease Control, 2014). The project location was at an internal medicine outpatient practice located in Granite City, Illinois. Granite City has a poverty rate of 17.6%, which is higher than the county (14.4%), the state (12.6%) and the national (12.3%) rates

(United State Census, 2017). When the project was conducted, there was no standardized process to screen patients for domestic violence and/or depression.

Evaluation

Evaluation of this project was two-fold. First, data were collected on the number of patients screened with the Partner Violence Screening Tool (PVS) and Patient Health Questionnaire – 2 (PHQ-2), and compared to the initial patients who are being screened, which was zero, as no screening process was in place before this project. Second, the clinic staff completed a brief questionnaire at the end of the initial implementation period in December 2019 to share feedback on the screening process, share ideas for any improvements that could be made to the process in the future, and share any thoughts on the feasibility of continuing the project long-term and/or expanding the project to other providers and offices.

In the practice location, there were three providers: two physicians and a certified nurse practitioner. The certified nurse practitioner, who is also the project leader, was the first to implement the screening practice. All patients presenting for regularly scheduled follow-up and preventive annual physical exams with the certified nurse practitioner provider were screened with both the PHQ-2 and PVS screening tools. The patients were given paper copies of the screening tools by staff to complete once in the exam room, and the nurse practitioner reviewed the responses during the exam. If a patient screened positive on the PHQ-2, further assessment was completed and the patient was either referred out to appropriate counseling/psychiatric services and/or was started on appropriate pharmacotherapy.

Secondary evaluation for the project also included a staff survey at the completion of the intervention period. Initially, staff were concerned that screening implementation would add time to the patient encounter and cause them to run even further behind schedule. However, staff

did not report this to be the case on the post-implementation survey. A total of 12 clinic staff (receptionists and medical assistants) participated in the survey. One hundred percent (n=12) of participants strongly agreed that the PVS screening tool was useful. Eighty-three percent strongly agreed and 17% agreed that the PHQ-2 screening was useful. The staff who reported "agree" rather than "strongly agree" regarding the PHQ-2 felt that a large portion of the patients already had depressive symptoms and may have already been identified as such, while they were not aware of any patients who had been identified as needing intervention for domestic violence. This baseline knowledge may have biased their answers to the questionnaire and may explain the difference in "strongly agree" ratings of the PVS versus the PHQ-2. One hundred percent (n=12) of the participants strongly agreed that both tools were feasible to continue in daily practice, and that both tools were useful for the patient population served by the clinic. No staff reported any concerns about the implementation of the project. Several staff felt the screening could save lives and improve quality of life.

Some patients who presented for follow-ups or physicals were missed with the screening process. This occurred due to staff forgetting to give the screening forms to the patient (which happened more frequently at the beginning of the intervention period), or if there were staff changes due to clinic needs, and the regular staff were not available.

Impact on Practice

Despite initial staff pushback over time management concerns with implementation of the screening tools, the staff had relatively few issues with the change in protocol. There were no patient complaints regarding the screening forms. By the end of the project, the screening process had become second nature to the staff and there were no issues with everyday use of the

tools. This was a simple change in practice which resulted in over 150 patients being screened for both depression and domestic violence, both which have lasting health impacts.

The screening process has continued for patients who are seen by the certified nurse practitioner at this location. This process could easily be implemented on a permanent basis for not only the participating provider in this project, but also for the other two providers in the same office, pending their approval. This could also be implemented system-wide to a variety of other internal medicine offices as well as family medicine, obstetrics/gynecology, and specialty care, as long as there was interest by the providers. This project could be shared with practice management for the hospital system to elicit interest about expansion to other offices. It may be useful for other offices to develop resource lists of available counseling, psychiatry, housing, and domestic violence resources in their local area, as these services vary widely by location.

Conclusion

The implementation for the nurse practitioner's patients went smoothly, and it is hoped that the other providers might also adopt this same protocol for their patients in this high-risk community. This project demonstrated that a screening process could be successfully implemented in an internal medicine practice. Future projects may focus on efforts to include all providers in a practice in the screening process as a regular part of patient care.