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Building a Community-Academic Partnership to Improve Screening for Intimate Partner Violence: Integrating Advocates in Healthcare Clinic Settings

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# Abstract

## Aims

To develop an innovative community-academic partnership to advance, test and promote intimate partner violence screening and referral protocols by comparing the effect of integrating intimate partner violence advocates versus enhancing medical training in medical clinic settings serving women from vulnerable populations. Detecting intimate partner violence in healthcare settings allows for survivors to connect to safety and referral resources prior to violence escalating. Screening for intimate partner violence and connecting patients to referral resources requires creating a safe and trusting relationship between healthcare providers and patients. Developing screening and referral protocols responsive to survivors' needs requires involvement of clinic staff, survivors and community agencies that support survivors.

## Design

Three phases of the project include Discovery, Implementation and Dissemination. Mixed-methodology will help in understanding current practices and effects of interventions.

## Methods

Actions included in each phase: Discovery: 1) nurse-led focus groups of clinic staff, providers and survivors to understand current clinic practices; 2) retrospective chart review of the number of screens performed, positive screens detected and interventions performed. Implementation: 1) randomization of patients to be interviewed by a trained advocate or by healthcare provider with enhanced training; and 2) assess the number of screenings and referrals performed in each arm and 3) evaluate outcomes of intervention. Dissemination through: presentations, manuscripts and policy recommendations at the institutional and regional level. This IRB-approved proposal was funded in July 2021 by an Advancing a Healthier Wisconsin grant.

## Discussion

The partnership has improved channels of communication and understanding between diverse clinical care providers, survivors and community agency staff as they navigate the complex challenges to the development and integration of screening and referral protocols.

## Impact

This project will provide evidence of the most effective intimate partner violence screening and referral methodology that can be utilized in a wide variety of medical settings.

# 1 INTRODUCTION

## 1.1 Effective screening and referral for intimate partner violence

Identifying and connecting survivors of intimate partner violence (IPV) to referral resources that offer safety and ongoing support is critical to survivors' physical and mental health of and to prevent continued and escalating violence. To a greater extent than routine screening for physical health issues (e.g. high blood pressure, cancer), effective IPV screening requires trust, rapport between the patient and healthcare provider and a deep understanding of the issue among professionals conducting the screening. A one-time screening outside the context of a trusted relationship is likely ineffective in promoting disclosure for all patients experiencing IPV and utilization of recommended referrals. IPV is a community concern and identifying survivors and linking them with resources needs a community approach.

To effectively address complex problems in a community, a community-engaged approach is necessary. With a community-engaged approach, academic researchers collaborate with peers from other sectors to work together to apply knowledge to community concerns (Gelmon, **2013**). In this community-engaged approach, community and academic partners work together as equals. All must be at the table as design begins in a project. Teams of IPV survivors, community agencies providing service to survivors and interdisciplinary academic researchers can work in partnership to design and test meaningful protocols that will create awareness, promote regular screening and generate survivor connection to referral resources.

# 2 BACKGROUND

## 2.1 Prevalence and impact of intimate partner violence

IPV impacts over 12.5 million adults in the U.S. annually (Whitaker et al., **2013**) with over a third of (36.4%) women experiencing physical violence, rape, or stalking by an intimate partner in their lifetime (Smith, **2018**). IPV is linked to a host of negative outcomes (Campbell et al., **2009**) and carries an estimated annual cost in the U.S. of $594 billion (Peterson et al., **2018**). The actual prevalence and true cost are likely much higher as IPV is regularly underreported in both self and official reports due to stigma, distrust of the system, economic dependency on the abuser or fear of losing custody of children (e.g. Felson et al., **2002**; Gwinn, **2015**). The economic cost of IPV has likely risen during the COVID-19 pandemic as the incidence and severity of violence have risen (Gosangi et al., **2021**).

IPV disproportionately impacts vulnerable groups such as pregnant women (Lutgendorf, **2019**) and people of colour (Evans et al., **2021**), with around half of all Black, American Indian/Alaska Native and multi-racial women in the United States experiencing IPV during their lifetime (Smith et al., **2017**). Young women of colour experience IPV at higher rates than any other group (CDC, 2009), but most do not report the violence or seek help from any institution (Evans et al., **2021**). Only about a third (34%) of survivors sustaining injury from IPV seek medical care for those injuries and fewer disclose the true cause of their injuries to providers (Truman & Morgan, **2014**).

Fortunately, effective services that offer safety and healing for IPV survivors (e.g. advocacy, support groups, safety planning, restraining orders, emergency shelter, etc.) do exist in many communities through IPV service providers and other key community partners (DePrince et al., **2012**; Hackett et al., **2016**). Yet many survivors remain unconnected to these vital resources due in part to the isolating nature of IPV, lack of knowledge of existing resources and hesitancy to reach out for help. The challenge is identifying those experiencing IPV and connecting them with resources in their community that exist to serve them. Professionals across many human service sectors must work to effectively identify survivors among those they serve. After identifying survivors, they must work to build trust and rapport to successfully refer survivors to services that fit their needs and desires.

## 2.2 IPV screening in healthcare settings

There are several evidence-based and widely implemented protocols for screening and connection to resources that exist in some sectors, such as the Lethality Assessment Protocol (LAP) used by law enforcement (Messing et al., **2015**). Utilizing LAP has encouraged survivors to protect themselves by hiding keys, money and other belongings, establishing a code word with friends and family, asking a neighbour to call the police if violence begins, hiding their abuser's weapons and going someplace their abusive partner cannot find them (Messing et al., **2014**). Despite LAP's effectiveness, similar widely used protocols do not exist in other sectors that regularly intersect with IPV survivors, such as healthcare. Importantly, screening in healthcare settings may open the door for survivors to connect to services prior to violence escalating to the extent that law enforcement is involved. Some IPV survivors access healthcare to deal with an injury or condition caused by IPV (e.g. an emergency room visit after an acute assault, a clinic visit to address lingering symptoms of assault, etc.). Many others, however, access healthcare to address routine issues outside of IPV (e.g. annual physicals, OB-GYN visits during pregnancy, urgent or emergent care to address illness and injury not caused by IPV). With routine screening for IPV by nurses and other healthcare providers in a broad variety of settings, the door to safety for survivors can be opened earlier, preventing escalating IPV.

Universal screening for IPV is recommended in healthcare settings where it is conducted privately, safely and comfortably. Healthcare providers, nurses and other clinic staff may screen for IPV when reviewing social determinants of health. However, there is no consensus on the optimal setting or method (Neslon et al., **2012**). In a review of IPV screening tools (Neslon et al., **2012**), five screening tools were identified with high diagnostic accuracy, face validity of items, psychometric specificity and brevity. Brevity is important for implementation in fast-paced environments like healthcare clinics. Another recommendation for routine IPV screening is the availability of adequate resources for identified positive cases (Nelson et al., **2012**). Implementation of LAP, for instance, requires a partnership between a law enforcement agency and an IPV service provider in that community. In the same way, screening and referral protocols for healthcare settings should be developed and implemented in close collaboration with local IPV service providers.

## 2.3 IPV Advocates for IPV screening

Even in settings that implement universal IPV screening, not all survivors disclose the violence. There are many valid reasons for hesitancy: disclosure may put them in danger if their abuser finds out, fear of unwanted law enforcement or child protective services involvement, not ready or no real economic option to leave abuser, distrust of the person or agency asking (Bair-Merritt et al., **2010**; Rizo & Macy, **2011**; Tillman et al., **2010**). For these reasons, the setting (over the phone, in person, electronic, etc.), the rapport and trust built with the survivor and the confidentiality / reporting requirements of the professional asking are all likely to play an important role in determining how effective screening is in promoting disclosure and connecting the survivor to safety and referral resources.

Utilizing IPV advocates in healthcare settings may provide a number of benefits to successfully identify IPV survivors among the broader patient population and refer them to services. Importantly, IPV advocates often better reflect the racial, ethnic and social class of the patient population. Thus, advocates may be better able to build trust quickly in a busy clinic particularly when their racial, ethnic and social class more closely matches the patient population (Thotis, **2021**).

In addition to more closely matching the racial and ethnic identity of patients, IPV advocates receive special training in the complex dynamics that characterize violent intimate relationships and reasons why leaving a relationship is difficult and dangerous for survivors. IPV advocates are solely focused on IPV intervention. Healthcare providers, on the other hand, might receive training on IPV but have myriad other issues to assess and treat during patient interactions. An IPV advocate within a healthcare clinic setting is well positioned to develop trust and rapport required to connect the survivor to ongoing support and services as opposed to the more typical protocol following screening in which healthcare professionals provide the survivor a referral card or brochure.

IPV advocates under most jurisdictions in the United States can operate confidentially. This is important considering that a key reason many survivors are hesitant to disclose the violence in their relationship is their fear of unwanted involvement of other systems (e.g. law enforcement, child protective services) that often follows disclosure to professionals with mandated reporting responsibilities such as nurses, physicians or licensed social workers. Although advocates can and do make reports to law enforcement and child protective services in certain scenarios, they have more freedom to determine whether a report is appropriate in each specific case given their protected confidential status. Thus, they can more readily provide safety planning, support and advocacy in line with the survivor's individual circumstances, preferences, comfort and readiness for change.

The primary concern in utilizing IPV advocates within healthcare settings is cost and resources. Integrating an additional professional in a clinic is a costly undertaking for too often under-resourced clinic settings. An alternative to having a specially trained IPV advocate on site is to thoroughly train and support existing nurses and other clinic staff to safely screen, build rapport and connect patients to IPV support and resources. Training and utilizing existing clinic staff builds expertise in screening for IPV and builds cultural responsiveness and compassion. It allows for the connection of survivors to resources within the current staffing structure which is a more cost-effective and perhaps sustainable model.

# 3 THE STUDY

## 3.1 Aim

The primary aim of this project is to develop an innovative community-academic partnership to advance, test and promote IPV screening and referral protocols by comparing the effect of integrating IPV advocates versus enhancing medical training in medical clinic settings serving women from vulnerable populations

Following the LAP model, screening patients for IPV and connecting patients that disclose violence to services could significantly reduce serious injury and necessary law enforcement involvement. Based on this concept, an interdisciplinary team is developing an innovative community-engaged partnership in Milwaukee, Wisconsin. The team will develop, test and disseminate an IPV screening and referral protocol that is responsive to survivors' needs, scalable to practice settings and reflective of the best clinical practice in IPV advocacy. This partnership was born out of Clinical & Translational Science Institute (CTSI) of Southeast Wisconsin convened conversations between an interdisciplinary team of academic researchers from three local institutions. The academic team includes physicians and Ph.D. faculty from disciplines ranging from nursing and psychiatry to social scientists. All members are specialized in approaches to culturally competent and responsive care. The team is also demographically diverse in race, gender and global and national geographic origin.

As the team shared their interests, they invited community organizations to share their concerns about community health and wellbeing within Milwaukee's communities of colour. The team developed a collaborative working relationship with Sojourner Family Peace Center (FPC), the state's largest provider of IPV prevention and intervention services. From the early days of the relationship, academic and community team members have continuously engaged in deep, meaningful discussions and worked to determine the need of the community. These conversations with FPC turned the team's attention to the risk of increased IPV and reduced access to services during COVID as well as the opportunity for improved IPV screening in healthcare settings to identify and connect survivors to services. The FPC has established strong, trusted relationships with IPV survivors whose perspective is critical in developing an acceptable, culturally appropriate screening and referral protocol. The team was able to attract a director of a clinic that serves a significant number of patients who identify as Black and patients with limited financial means as an additional partner. The team applied for and received grant funding to develop the inter-institutional partnership for developing effective IPV screening and referral practices for healthcare settings. This community-engaged partnership is invested in this project because it was conceived of through an ongoing dialogue between academics, nurses and other healthcare providers, community partners and IPV survivors.

## 3.2 Integrating IPV survivors as partners in the design process

Two IPV survivors, both women who identify as Black, have been a part of project planning and meetings since the outset to give them an equal seat at the table in designing training for healthcare staff, clinic screening and referral protocols and effectiveness study. Both survivors on the team are mothers of children they share with a partner who has been violent towards them. As the patient population of the study sites includes majority Black pregnant women, the survivors are well positioned to advise the team on lived experiences and challenges of women from the clinic patient population as well as issues of health equity.

## 3.3 Design/Methodology

The team took into consideration the three levels of organizational culture articulated by Mannion and Davies (**2018**) in the design of the project: visible manifestations, shared ways of thinking and deeper shared assumptions. Considering visible manifestations of healthcare culture, the team's initial assessment included an examination of the separations between primary and social care, the physical layout of each clinic involved in the study, staffing patterns and patient participation and feedback. The team aims to integrate social care into these primary care settings through the introduction of an IPV advocate. The team will attempt to alter a shared way of thinking through implementing training and awareness of IPV in the clinic setting. Ultimately the team is working towards deeper shared assumptions about IPV, how to identify clinic patients who are experiencing IPV and to more effectively connect them to supports and services.

The engagement of champions in healthcare settings is imperative to sustain changes in practice, policies and guidelines (Saberi et al., **2021**); therefore, in addition to the use of advocates, champions of IPV will be selected within clinic settings to support the sustainability new innovations. The role of the clinic champion may be filled by nurses, social workers, medical staff, management staff or individuals who emerged with interest or passion about the intervention (Woods-Burnham, **2020**). Attributes of clinic champions include implementation of the evidence-based intervention while problem-solving organizational barriers that may have the potential to thwart sustainability of the practice change (Bonawitz et al., **2020**; Saberi et al., **2021**; Woods-Burnham, **2020**). Clinic champions may also serve as an internal support resource for IPV survivors, promote faster initiation of the new intervention, enhance staff motivation and engagement in the project and promote sustainable efforts after proposal funding has ended. Participating clinics will identify a champion(s) in the clinic who will undergo extensive training on IPV by FPC and will serve as the internal on-site person who will be involved in providing support to identified IPV survivors.

## 3.4 Ethical considerations

Screening for IPV can introduce considerable and real danger if a patient discloses violence in the household and that disclosure is discovered by their abuser. Therefore, ethical considerations of any IPV screening study must prioritize the safety of patients. Materials provided to patients for the purposes of this study will be included in broader resource folders so as not to draw attention to IPV-specific resources. Stickers will be placed on any IPV-specific resources provided to patients indicating that these resources are given to all clinic patients, so as not to raise alarm if a patient's abusive partner finds these resources. Written consent will be obtained from research participants. Study consent forms and patient facing materials will use broad terms not specific to IPV (e.g. ‘a study about relationships during pregnancy’). This study protocol was approved by a medical college Institutional Review Board in July 2021.

# 4 DISCUSSION

All members of the project team (i.e. IPV survivors, IPV service providers and academic researchers) will work together during the discovery & design, implementation and dissemination phases of the project, described below.

## 4.1 Discovery and design

During the discovery & design phase of the project, the team will investigate current IPV screening practices, identify opportunities for improvement, design comprehensive IPV training for healthcare clinic staff and design the effectiveness study to test the screening and referral protocol. The team will conduct a gap analysis examining current IPV screening practices at participating clinics for patients 18 years of age or older. On reviewing the screening methods clinics are currently using, the team will assess cultural appropriateness, current disclosure (positive screen) rate, referrals made following a positive screen and limitations in the ability to screen patients via a retrospective review of medical charts to determine disclosure rate, documentation of and referrals made for IPV in clinics prior to any intervention.

Focus groups will be conducted by nurse researchers to understand current screening practices in clinics and to develop an IPV screening protocol that is culturally appropriate and responsive to the needs and concerns of IPV survivors. Focus groups will be composed of IPV survivors, IPV service providers, healthcare clinic staff in varying roles (e.g. social workers, nurses, medical residents, medical assistants, etc.) and academic researchers. In addition to insights gleaned from focus groups, the screening and referral protocol will be informed by clinic champions in each participating clinic. Clinic champions will help with program design, implementation and sustainability beyond the project by promoting ongoing training and best practices in identifying and treating IPV in their home clinic and promote sustainability efforts after funding has ended. After analysing the current IPV screening system and lessons learned from focus group conversations with key stakeholders, the team will design an intervention effectiveness study to implement improved processes to screen for IPV and connect patients who disclose IPV to referral resources.

During this phase, the team will also set up the foundation to make recommendations for system and policy change on a wider scale by identifying stakeholders in local and state medical systems, diversity, equity and inclusion groups and relevant regulatory and governmental bodies. These stakeholders will review and help craft policy suggestions to improve IPV screening and decrease racial and socio-economic disparities in the experience and impact of IPV.

## 4.2 Implementation

During the implementation phase, the team will conduct the comprehensive IPV training for clinic staff, co-located specialized IPV advocates on-site and implement the improved screening and referral protocols at participating clinics. The training will be intended for healthcare staff of varying roles (e.g. nurse providers, staff nurses, physicians, medical residents, medical assistants, social workers, etc.) with the aim of creating a clinic-wide awareness and sensitivity towards IPV. The training will improve providers and clinic staff understanding and ability to screen for IPV in a way that promotes disclosure and successfully connects patients who are experiencing IPV to on-going services. This training module will be developed in collaboration with IPV survivors, IPV service providers and clinic staff.

Following clinic training, the team will implement and test a two-arm IPV screening program. All female patients 18 years and older presenting to participating clinics will be invited to participate in a project about relationships. Through the use of the term relationships rather than IPV, the team hope to decrease stigma and danger associated with identifying as an IPV survivor, particularly when the abuser is present. Patients will be randomized into two groups where they will be screened for IPV: Group 1: IPV screening by a trained healthcare professional. Group 2: IPV screening by an IPV advocate. The team will analyse the relative effectiveness of each arm as well as comparison to pre-intervention screening protocols present in the clinics (e.g. a one-time ask outside the context of a trusting relationship). The following outcomes will be examined: 1) percentage of disclosures / positive screens and 2) number of accepted referrals to on-going support by IPV service providers.

Along with reviewing the effectiveness of the screening intervention, advisory board meetings will be held throughout this phase to inform the stakeholders about the overall project and make necessary adjustments. The advisory board will be sought for advice on introducing environmental changes to the clinics, data reporting, effectiveness of clinic champions and overall success of the study interventions.

## 4.3 Dissemination

Based on the results of the implementation and analysis, the team will develop recommendations for the healthcare clinics, medical and nursing education systems, and for city and state leaders to advocate for improved IPV training, screening and referrals. If trained providers and clinic staff are just as effective at promoting disclosure and connection to resources as a specialized IPV advocate, the team will make recommendations for changes at medical, nursing, medical assistant and social worker schools' curricula as well as a focused training during medical residency. If IPV advocates are most effective at screening and referral, the team will make clear recommendations to embed specialized IPV advocates in clinic settings. If local clinic champions help improve the clinic environment and screening and referral process, the team will make recommendations to retain and support existing clinic champions and identify and support new clinic champions in each environment that utilizes the protocol.

The team will meet with key stakeholders on the Advisory Board that will recommend and implement changes in educational curriculum and training requirements to incorporate IPV awareness, screening and referral. If current protocols in the healthcare system are indeed missing the identification of IPV survivors, the team will meet with the leadership of participating healthcare institutions to discuss findings and suggest improvements to the system. Similarly, the team will inform stakeholders at the county and state level to advocate for policy changes. The screening and referral recommendations are critical to close the gap in health equity, given that women and particularly women of colour disproportionately experience IPV.

## 4.4 Limitations

The team will compare IPV disclosure rates and connection to referral resources in a retrospective group of patients as well as the two prospective arms described above (i.e. screening by IPV advocate and screening by trained medical staff). The design of the effectiveness study is quasi-experimental in that the retrospective group of patients received care during a different time period than the prospective groups. Differences in rates of disclosure or connection to referral resources could differ because of the larger socio-political or public health climate rather than because of differences in screening protocols. For instance the retrospective group received care earlier in the COVID-19 pandemic and may have been less likely to connect with IPV resources to reasons other than clinic screening protocols (e.g. concern about catching the virus, services less likely to be open or operating at lower capacity, etc.).

# 5 CONCLUSION

This study will identify the best approach to sustain and perpetuate IPV screening and referrals in a healthcare clinic setting. Results will indicate whether the improvements in screening introduced in clinic settings (i.e. screening via trained providers and clinic staff and screening by a confidential, specialized IPV advocate) improve rates of disclosure and connection to resources. Ultimately, through collaboration with IPV survivors, IPV service providers and academic researchers, the team will establish a model for addressing a multifaceted health disparity through a team whose make-up is diverse enough to tackle a complex public health challenge, but can work cooperatively, equitably and effectively.

# CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

# PEER REVIEW

The peer review history for this article is available at **https://publons.com/publon/10.1111/jan.15284**.

# DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study

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