

Experience of introducing screening for intimate partner violence and reproductive coercion in an urban sexual health clinic

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Typically, only one-third of women experiencing intimate partner abuse disclose this to their general practitioner.¹ Intimate partner violence encompasses a range of types of abuse, including emotional, physical, financial, sexual, technological, cultural and reproductive coercion (RC).

Although not a new issue, RC has only recently been described in the literature as a form of control used by intimate partners with the intention of limiting their partner's reproductive rights.^{2,3} This includes forcing a person against their wishes to become pregnant, continue an unintended pregnancy, or have an abortion.³ A recent study in Queensland estimated that one in three survivors of IPV has experienced RC.²

While it is acknowledged that IPV can be perpetrated and experienced by people of all genders,^{4,5} most people experiencing IPV in Australia are women.⁴ In Victoria, IPV was found to be the leading risk factor contributing to the disease burden of women of reproductive age.⁶

Systematic screening has the potential to enable early identification of women affected by IPV before serious physical or psychological harm has occurred.⁷ Screening in primary care offers the ideal opportunity for 'invisible' abuse to be identified by general practitioners (GPs), who are well-placed within the healthcare system to connect survivors with counselling or other much-

Abstract

Background: Intimate partner violence (IPV) and reproductive coercion (RC) can result in serious psychological, social and physical harm. Screening patients for IPV/RC has the potential to identify and assist patients who may not otherwise discuss this with a health practitioner. Targeted screening for those with a range of specific presentations including many sexual and reproductive health issues has been recommended, but universal screening has not.

Methods: The implementation and evaluation of a screening program for IPV and RC in an urban sexual and reproductive health clinic is described.

Results: The program enabled patients who had been exposed to IPV and/or RC to receive assistance and support. Screening was highly acceptable to patients, and the reception and clinical staff became both highly supportive of screening and increasingly confident to assist patients who were exposed to IPV and/or RC.

Conclusion and implications for public health: This program could be adapted for use in a number of healthcare settings and lead to positive health outcomes.

Key words: screening, intimate partner violence, reproductive coercion, primary care, sexual health clinic

needed services.⁷ Survivors want their GP to raise the issue of partner violence⁸ and would disclose exposure to violence if directly asked.¹ What survivors require from their GP is a safe and private environment for disclosure, compassionate and respectful listening, and timely referral to counselling or other appropriate services.⁸

The American College of Obstetrics and Gynaecology recommend screening women and adolescents at least annually for IPV and RC.⁹ However, a recent Cochrane systematic review does not support universal screening in healthcare settings due to a lack of evidence that screening reduces morbidity

and mortality from IPV.¹⁰ International, national and state organisations recommend targeted screening for IPV in patients who present with potential indicators of abuse (i.e. STI, unintended pregnancy, sexual dysfunction, pelvic pain and sexual assault).^{7,11,12} Screening for RC when screening for IPV is also recommended.^{2,13}

Despite these recommendations, clinicians feel apprehensive about asking their patients about IPV. They report time constraints, awkwardness in broaching the subject, lack of training in how to respond to disclosure, feelings of helplessness, and lack of knowledge of community services

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for referral.¹ There are limited guidelines for service providers in general practice and other health settings in Australia on how best to implement screening of those at risk. In response to this context the authors, in consultation with consumers, external advisors and stakeholders, developed and implemented a pilot screening program for IPV and RC at Sexual Health Quarters (SHQ). The aim was to create a safe and effective program that could be sustained and transferrable to other settings.

SHQ is a not-for-profit organisation in Perth, Western Australia (WA) providing clinical services, counselling, information, and education services under the umbrella of sexual health for all people in Western Australia, including those with disabilities, migrants, sex workers, homeless people and travellers. Because many of the clinical issues seen are considered potential indicators of abuse,⁴ introducing routine screening for IPV and RC was considered to be justified at SHQ.

This paper describes the steps involved in the development and implementation of the screening program; the impact of the program on the number of counselling requests; and feedback from staff and patients in the first 12 months of operation.

Methods

Design and development of pilot screening program for IPV and RC

From July 2018 to March 2019 (i.e. over 9 months) critical steps were undertaken in preparation for the launch of the program on

27 March 2019. These included consultation with key stakeholders, systems and logistics planning, and education and training of staff across the organisation.

Screening questionnaire, brief risk assessment and referral pathways

A draft screening questionnaire was created, based on two existing Australian resources.^{7,14} It included two questions addressing IPV and three questions for RC. The final version (Figure 1) of the questionnaire incorporated feedback provided by 51 consumers and 77 clinicians in Western Australia, the SHQ Aboriginal Advisory Committee and WA's Humanitarian Entrant Health Service. This questionnaire was completed by the patient on paper and returned inside a folder together with other administrative forms to reception staff before seeing the clinician. Clinicians reviewed the completed screening questionnaire prior to the consultation. Patients whose English was not fluent were assisted by interpreters (in person or over the phone) and completed their questionnaires during the consultation and not while waiting.

Patients answering "yes" to any of the five screening questions had a brief risk assessment (Figure 1) conducted in private with the clinician and were offered a referral for counselling. This brief risk assessment was developed in consultation with the lead psychologist at SHQ. At least two counselling appointments were reserved every day for emergencies. This allowed the patients the option of accepting an

emergency appointment on the same day or returning on a different day. If the referral for counselling was accepted, SHQ counsellors conducted a full risk assessment and offered safety planning, links to key support services and ongoing counselling support. Follow-up after the initial consultation included a range of options tailored to suit the needs of the patient, including a face-to-face appointment at SHQ, a phone appointment with an SHQ counsellor, or a referral to a different agency for support.

Records were strictly managed to minimise the risk of a partner (who may attend a future consultation with the patient) viewing details of screening and assessment. Screening questionnaires were scanned into the patient's records as an attachment. The brief risk assessment, counselling referral notes and counsellor's assessment were kept as letter attachments. These documents were all hidden from the main clinical window of SHQ's clinical software.

Modification of the clinical environment

A private area separate from the waiting room, but visible to reception staff, was created to provide a safe environment for patients to complete the administrative paperwork in which the screening questionnaire was embedded. Only patients (and interpreters) were allowed into this area. Accompanying parties were requested to remain in the main waiting area. Relevant posters and leaflets^{15,16} were strategically placed throughout the clinic.

Policies and procedures

Given its core business, all patients presenting to SHQ have possible indicators for IPV and/or RC.^{7,11,12} Consequently, it was agreed that all patients would be offered screening on presentation to SHQ (routine universal screening). Other policies and procedures ensured a safer experience for both patients and staff during the program (e.g. dealing with violent partners in the waiting room, increased availability of emergency counselling appointments for patients and staff, and paid family and domestic violence leave for staff).

Staff training

All front-line staff (clinical and reception) received the same theory training by external experts on IPV and RC in Australia.¹⁷ Additional practical sessions were organised for the clinicians on how to identify and

Figure 2: Intimate Partner Violence screening questionnaire and brief risk assessment.

Screening tool

- Has a partner ever put you down, humiliated you or tried to control what you can or cannot do? YES/NO
- Has a partner ever hurt or threatened to hurt you? YES/NO
- Has a partner ever placed pressure on you to become pregnant when you didn't want to? YES/NO
- Has a partner ever pressured you to use contraception (birth control) when you wanted to become pregnant? YES/NO
- Has a partner ever tried to influence your decision to continue with a pregnancy when you wanted an abortion, or to have an abortion against your will? YES/NO
- I prefer to answer these questions face-to-face with a clinician
- I do not wish to be asked these questions again on subsequent visits to SHQ

Brief risk assessment

- Client states this is in relation to a: current /past relationship
- Do you feel safe to go home now?
- Would you like help now with your situation?
- Are you worried for the safety of your children?

respond to positive disclosures of IPV¹⁸ and for reception staff on how to deal with abusive partners at reception.

Data collection and analysis

A) Patient data

Inclusion criteria for the study were identifying as female and aged 16 and over. All eligible patients presenting to SHQ from 27 March 2019 to 27 March 2020 were given written information about the study and a consent form. This expressly stated that care would not be affected by decisions about participation. Consent forms were completed in the private area along with the screening questionnaire, returned to reception prior to seeing the clinician, and kept by reception staff; thus clinical staff were not aware of whether patients had chosen to participate or not.

Using SHQ's clinical software (*Zedmed*), the following information was collected from study participants' medical records: age, country of birth, postcode, date of screening, whether they had attended SHQ before screening implementation, the answers to screening questions and the brief risk assessment, and the date of any counselling appointments.

Screening positive to IPV and/or RC was defined as answering "yes" to any of the five screening questions. Socioeconomic status was determined based on the SEIFA ranking¹⁹ of the patient's postcode.

B) Impact of program on counselling uptake

A simple descriptive statistical analysis was conducted on patient data using *Excel 365* to calculate the proportion of: those who screened positive for IPV/RC, new patients at the time of screening, those currently in a relationship with the abusive partner, and those accepting counselling appointments.

For statistical and funding purposes, SHQ counsellors routinely attributed a code at the end of each session that described the nature of the appointment. The total number of counselling appointments and the number of appointments coded as IPV were collated for the periods of 26 March 2018 to 26 March 2019, and 27 March 2019 to 27 March 2020. The total number of counselling sessions related to IPV before and after screening was implemented was compared with the total number of appointments per 12-month period.

C) Patient and staff feedback

Feedback from patients: Between 15 and 30 September 2019 (6 months into the program) all patients were invited to complete a two-question survey on paper at the end of their appointment, in a private space, before checking out of the clinic. The survey was to assess the acceptability of the screening questionnaire (Figure 2). While all patients presenting to the clinic during those two weeks were given the opportunity to provide formal feedback through this survey, only the results from consenting participants were included in the analysis. Patient ID numbers were included with survey responses to ensure that only data from those who had consented to the study were included.

A descriptive statistical analysis of the survey results was conducted as well as the inclusion of supplementary feedback comments from patients.

Feedback from staff: All staff with direct patient contact during the study period were invited to provide feedback on three occasions related to screening program implementation: one week before the program commencing, four months after commencement, and fourteen months after commencement. They were given written and oral information about the reason for this data collection. Anonymous consent was obtained online prior to the completion of the online feedback survey. Client support officers (CSOs), whose roles involved reception/administrative work, received a two-question survey (Figure 3) and clinical staff (nurses, doctors and counsellors) received a three-question survey (Figure 4).

Both groups had the opportunity to provide free text comments within their survey.

A simple descriptive statistical analysis of survey results was conducted as well as the inclusion of supplementary feedback comments from staff.

This study follows the World Health Organization's ethical and safety recommendations for domestic violence research.²⁰ Ethics approval was provided through the University of Western Australia Human Research Ethics Committee (RA/4/20/4896).

Results

In the first year of the program (March 2019–March 2020), 3,745 females aged 16 and over attended SHQ. Seventy per cent (2,623) provided consent and are included in this analysis. The screening program identified lifetime exposure to violence (IPV and/or RC) in 454 participants (17.3%), with 92 (20.3%) of them in a relationship with the abusive partner at the time of screening, representing 3.5% of the women screened. Of all the women who screened positive for IPV/RC, 277 (61%) had been patients at SHQ prior to the introduction of screening. None of these responders had had their experience of IPV identified in previous consultations.

Uptake of counselling services

Of the 454 women identified by the program, 86 (19%) accepted a referral to see a professional counsellor/psychologist. Of those, 63 (73%) requested an emergency appointment on the same day and 23 (27%)

Figure 2: Patient feedback survey and results.

Survey questions

- 1 – Do you agree that these questions should be asked of all SHQ clients? YES/NO
- 2 – Do you find it acceptable to answer these questions on paper before seeing a clinician? YES/NO
- 3 – Do you have any additional comments?

Examples of comments supportive of screening are:

"I'm so glad you are doing this! I especially approve of it being done on paper when the patient is separated from anyone accompanying them. If it's only brought up in the appointment, the patient may be under duress by the person coming in with them."

"I think it's a wonderful way of supporting women and putting them in touch with resources and counselling. I admire the initiative. Thank you."

Examples of comments which did not support screening are:

"Knowledge of presence of paperwork regarding partner violence may act as deterrent when seeking medical assistance."

"I'm worried if these questions are asked before meeting clinician a person may feel uncomfortable and leave because for some people these things may be too traumatic or hard to talk about."

opted to return for counselling within the following three months. The offer for same-day appointments appears to have been highly valued by both women who were in a relationship with the abusive partner and those no longer in an abusive relationship at the time of screening. For women in an abusive relationship, 79% of the counselling requests were for same-day appointments while for women no longer in the abusive relationship, this figure was 69%.

The number and percentage of counselling appointments for FDV/IPV increased following the introduction of the screening program. It rose from 1.5% (10 out of 661 appointments) in the 12 months prior to 19% (163 out of 854 appointments) in the 12 months after program implementation.

Feedback from patients

All study participants attending the clinic during the two-week period provided

feedback ($n=81$, 100% response rate). This sub-group of participants was representative of the overall sample of 2,623 female participants according to age distribution, country of birth, socioeconomic status and exposure to violence. Eighty of 81 patients (99%) agreed that the screening questions should be asked of all patients presenting to the clinic. Of these, 18 screened positive for IPV/RC. One person who screened negative for IPV/RC was uncertain about the screening approach. Seventy-seven patients (95%) found it acceptable to answer the screening questions on paper in the private area separate from the waiting room. The four patients who did not find the paper format acceptable had screened negative for IPV/RC. Some patients provided additional comments in the free text section (Figure 2).

I think it's a wonderful way of supporting women and putting them in touch with resources and counselling.

Feedback from non-clinical staff

Six CSOs (100%) completed the survey. As Figure 3 illustrates, prior to the introduction of the program, all CSOs had some concerns about patient flow in the clinic, however by 14 months, none had ongoing concerns. Of note, from the outset, all CSOs thought that it was important to ask patients about IPV/RC.

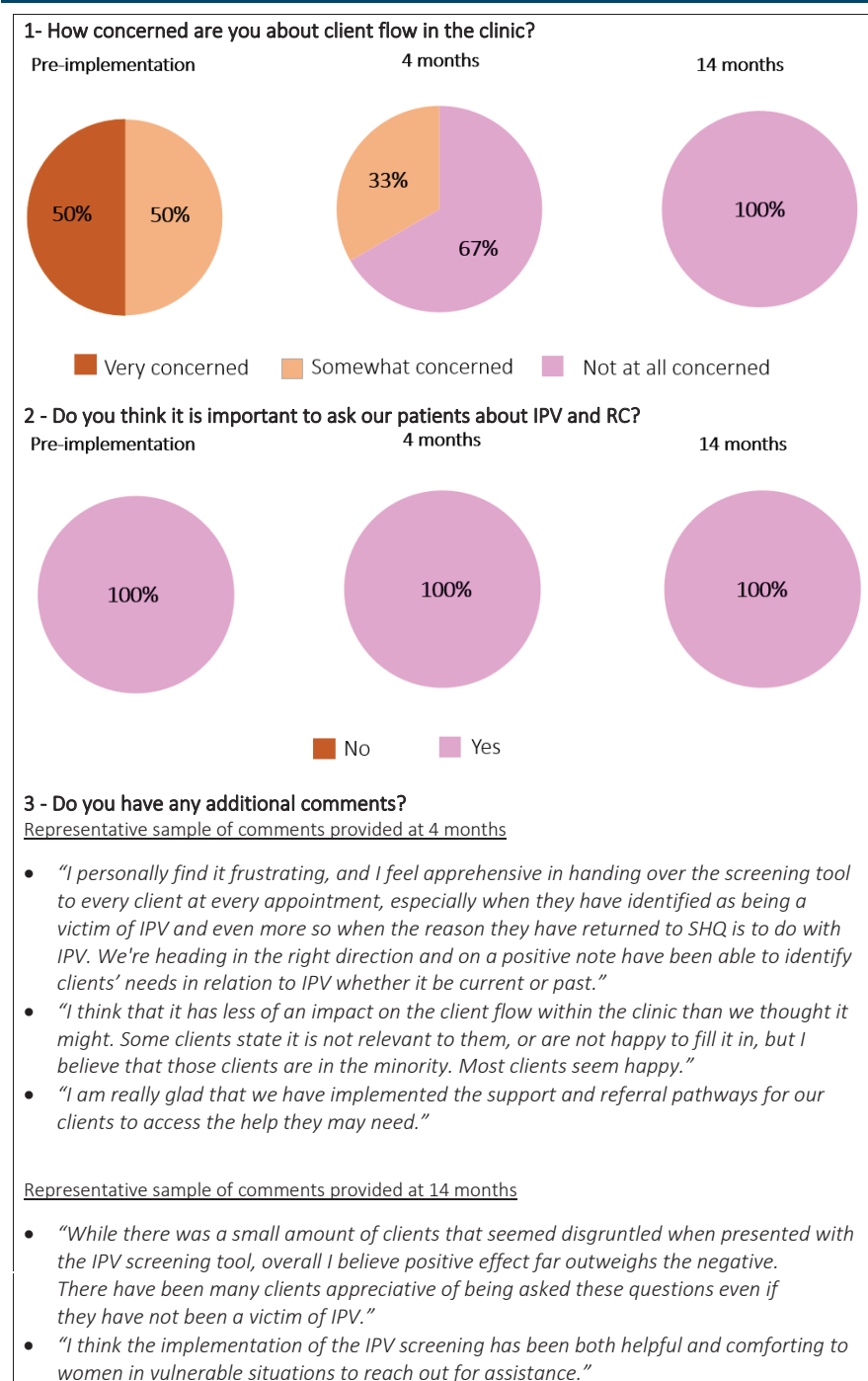
Some clients state it is not relevant to them, or are not happy to fill it in, but I believe that those clients are in the minority. Most clients seem happy.

Feedback from clinical staff

Sixteen out of 27 clinical staff completed the online survey prior to the implementation of the screening program and four months after implementation. Nineteen out of 20 clinical staff completed the survey 14 months after program implementation. Staff turnover during the study period accounts for the difference in the total number of clinicians employed at the different points in time the surveys were conducted. Like the CSOs, the clinicians' viewpoints shifted considerably over time (Figure 4). Within four months of the start of the program, 94% felt "very confident" in asking their patients about IPV and RC, 75% reported taking less time than expected in dealing with positive disclosures of violence and 94% would recommend that other primary care clinicians introduce screening in their practice.

It has been really rewarding work.

Figure 3: CSO feedback survey and results.



Discussion

This paper is the first study of its kind in Western Australia, and our findings and experience, along with those from other countries,²¹ may encourage and guide other clinical services in implementing screening for IPV/RC.

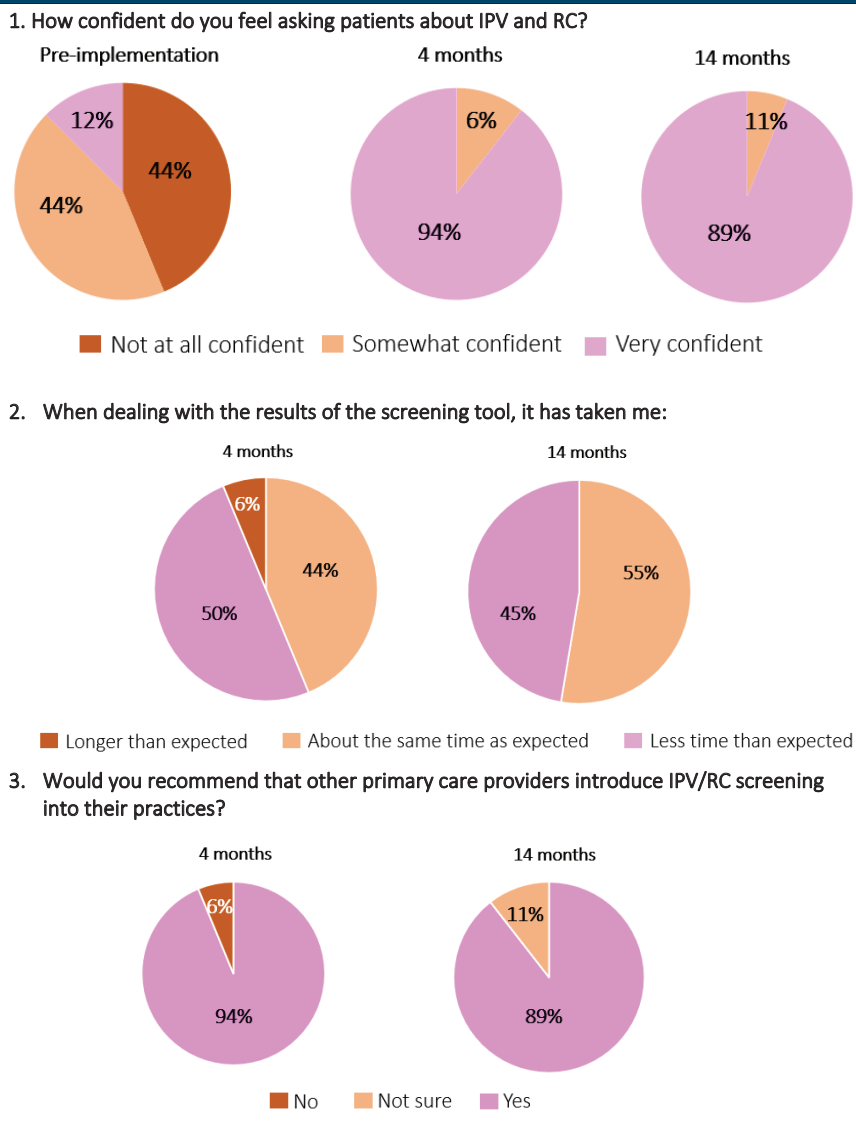
The reported lifetime prevalence rate of more than 17% is similar to others published in Australia,⁴ demonstrating the ability of the program to identify IPV/RC. Interestingly, the majority of those who screened positive (61%) had already been patients at SHQ for at least one year. Despite having formed a trusting relationship with their clinician and the clinic over the period of their attendance, these 277 patients only disclosed exposure to violence for the first time when directly asked through the screening program. This supports the view that patients find it easier to be asked about IPV, rather than raise the issue themselves.¹ It is reasonable to conclude that the screening questionnaire enabled disclosure in this group of women.

Notably, 39% of patients who screened positive did so on their first visit to SHQ. The provision of a private, safe and welcoming environment and the simplicity of the questionnaire are the most likely contributing factors to the patients' option to disclose, even before meeting and forming a trusting relationship with a clinician.

Counselling therapies provide emotional support and decrease depression and anxiety among survivors²² as well as linking them with key agencies in the community. This project demonstrated the ability of the program to connect survivors of IPV and RC with counselling services. The overall number of counselling appointments for IPV in the first year of screening was 16 times higher than in the previous year. It is reasonable to suggest that the increase in counselling appointments for IPV between the two time periods was due to the implementation of the screening program. The study recruitment period ended just before the first COVID-19-related lockdown in Western Australia, so the increase in counselling appointments was not related to any increased incidence of IPV due to the pandemic.

The high uptake of counselling appointments even among those who had already left the abusive relationship is suggestive of psychological impacts lasting beyond separation from a partner and further

Figure 4: Clinicians feedback survey and results.



4. Do you have any comments or feedback?

Representative sample of comments provided at 4 months

- "Although I was apprehensive at first, I'm so glad we introduced the screening tool"
- "It has been really rewarding work. I'm glad that we're doing it."
- "I have been surprised at how easy it has been to do in the clinic. I think having the counsellors readily available has facilitated it very well. I would be nervous about screening if they were not readily available."
- "Several patients have expressed appreciation that we are asking the questions, for some patients it is the first time they have ever been asked"
- "I haven't had to facilitate a crisis from the IPV survey yet, so some underlying angst about that happening at some point. But now feel much more reassured about what to do when this happens. Whereas prior to starting I was quite anxious about this situation."

Representative sample of comments provided at 14 months:

- "The training prior to launching the questionnaire was excellent. It helped with building confidence and acceptance. Client feedback has been positive, the trainee feedback is positive."
- "It has been a very rewarding experience. I was surprised by how agreeable clients were to being screened. What comes to light is the lack of resources in the community for IPV, as when we go to refer to another service, there are long wait times and also exclusion criteria."
- "Felt very supported, especially knowing had back up of organisation and counselling staff. In other settings it is difficult as there is not always a clear pathway of referral or resources available to assist staff in helping patients."

highlights the need for survivors to have access to high-quality counselling services, a finding supported by other studies.^{2,23-28}

The uptake of emergency counselling among 14% of survivors (including those who had already left the abusive partner) was higher than expected, as most of the women presenting to SHQ had made an appointment to see a clinician for reasons other than IPV or RC – such as for contraception, STIs, unintended pregnancy or cervical screening. Some had partners, friends and/or relatives waiting for them in the waiting room, jobs to go back to, children to be picked up, or other commitments planned for the day. Given these potential barriers to accepting same-day appointments, one could argue that the true desire for same-day appointments was higher. These findings highlight the value of having efficient systems in place for same-day referrals, ideally within the same clinic. Women may need and want to see a counsellor but tight control (including GPS surveillance²⁹) by their partner might prevent them from seeking such professional support at a different location for fear of reprisals.

Despite the well-documented barriers for clinicians in screening for IPV,¹ it was encouraging to observe the change in confidence and attitudes by SHQ staff over time. Most clinicians within four months of commencing the program reported that they were very confident in addressing IPV and RC with their patients, thought that dealing with a positive disclosure took less time than anticipated, and recommended that other clinicians implement screening into their routine practice.

An overwhelming proportion (99%) of patients was supportive of routine screening in the clinic and in favour of screening on paper before seeing the clinician. This is reassuring, as we were aware of the risk of psychological distress resulting from screening. The strong support from patients is similar to other studies which found that, generally, most women are in favour of universal screening³⁰ and that self-completion methods are preferred over direct enquiry by a clinician, especially by those who have experienced IPV.³³⁻³⁵

This screening program was not implemented overnight. It took nine months to ensure that the clinic and staff were ready. All preparatory steps were undertaken in response to not only the barriers described in the literature but also the anxieties and concerns expressed

by staff members. We believe the support for this program by staff and patients is attributable to thorough preparation to ensure a safe and efficient program.

This study was limited by several factors. Firstly, while all non-English speakers were provided with an interpreter for their appointment at no extra cost, the questions were only written in English, which might have deterred some patients from participating, contributing to selection bias towards those who speak English. Secondly, this study does not describe the patients' own assessments of counselling sessions, nor does it assess whether counselling affected re-exposure to IPV or overall health and wellbeing. While a recent review²² found evidence of a reduction in depression and anxiety following psychological interventions, more studies are required to assess the long-term impact of counselling for IPV (in terms of morbidity and mortality). Finally, due to staff turnover during the study period, the cohort of clinical staff from whom feedback was sought at 14 months was slightly different from the earlier cohorts at 0 and 4 months. Therefore, feedback at 14 months cannot be directly compared to feedback obtained earlier in the program. Despite the limitations described, there is sufficient evidence that this screening program is acceptable to both patients and staff, can detect IPV effectively, and most importantly, increases access to counselling services for survivors in a manner that is safe for both patients and staff.

While routine screening for IPV in primary care is not yet recommended,^{11,36} strong consideration should be given to introducing screening programs, such as the one described in this paper, to clinical settings where a significant proportion of the patients present with possible indicators for IPV. This includes some primary care services, other sexual health clinics, gynaecology clinics, antenatal clinics and termination services. This would ensure that the first point of contact for survivors is of high quality, is accessible and responsive, so that people are not required to retell their story to multiple services, multiple times.

Policy makers cannot solely rely on the goodwill of clinicians to implement these changes into their routine practices. They too have a role if change is to be sustained and widespread. There is an urgent need for commitment from national and state leaders for actions which will enable change.

Firstly, all healthcare professionals should receive adequate training in identifying and responding to IPV – while at university and as part of compulsory professional development activities. Secondly, at least two new MBS item numbers should be created – one to appropriately support the clinician who screens patients for IPV, and another for the clinician who assists a survivor of IPV. Thirdly, more funding should be put in place to increase the number of emergency counsellors available to assist survivors, including the availability of counsellors within each primary care service. These changes are critical to ensure that those who need counselling can readily access it.

By signing the National Plan to Reduce Violence against Women and Their Children in 2010, the Council of Australian Governments pledged to “create services that meet the expectation of victims and their children” (national outcome 4).³⁵ Both survivors and clinicians have now provided a wealth of published knowledge on how to make such services work. It is time to put that knowledge into practice by making meaningful change.

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