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Intimate Partner Violence among Pregnant and Parenting Women: Local Health Department Strategies for Assessment, Intervention, and Prevention

Introduction

This issue brief illustrates the public health importance of intimate partner violence (IPV) among pregnant women and shares promising approaches to the identification, intervention, and prevention of IPV. This issue brief will highlight four local health departments (LHDs) that have integrated screening and violence prevention activities into existing services (such as home visiting programs and family planning programs) for women of childbearing age.

Background

According to the Centers for Disease Control and Prevention (CDC), approximately 1.5 million women are raped or physically assaulted by an intimate partner each year.[1] The greatest risk of violence occurs during the reproductive years. Women of childbearing age may be at a higher risk for IPV. Research indicates that a pregnant woman has a 35.6 percent greater risk of being a victim of violence than a non-pregnant woman.[2] The estimated prevalence of violence against women during pregnancy ranges from four percent to eight percent.[3]

The CDC defines IPV as abuse that occurs between two people in a close relationship.[4] The term "intimate partner" includes current and former spouses and dating partners. IPV includes four types of behavior: physical abuse, sexual abuse, threats of physical or sexual abuse, and emotional abuse.[4] Domestic violence, dating violence, partner abuse, spousal abuse, and battering are all terms used to describe violence that occurs between partners in a current or previously intimate relationship.

This issue brief will focus on IPV during or around the time of pregnancy. Women experiencing IPV both prior to and during pregnancy may be more likely to delay entry into prenatal care.[5] These women are also at increased risk for multiple poor maternal and infant health outcomes. Pregnancy complications, such as low maternal weight gain, infections, high blood pressure, and vaginal bleeding, are significantly higher among abused women.[6] In addition, women who experience violence prior to or during pregnancy are more likely to deliver pre-term or low birth weight infants.[6]

Because abuse during and prior to pregnancy is associated with harmful consequences for both mother and child, it is a significant public health concern. Research from the Healthy People 2010 initiative demonstrates that IPV is linked with eight of 10 leading health indicators—violence both affects and is affected by these health issues. Relative to non-abused women, women experiencing IPV are less likely to practice responsible sexual behavior, are at increased risk for mental health disorders, are less likely to have access to care, and are at higher risk for substance abuse.[5] While women who experience violence come from all social backgrounds and every racial and ethnic group, women who are physically abused are more likely to be young, unmarried, less educated, and have low household incomes.[7]

Accurate screening is the first step toward IPV prevention. The American College of Obstetrics and Gynecology recommends that all healthcare providers screen all patients for violence at regular intervals: during routine annual examinations, during preconceptual visits, once per trimester for pregnant women, and during postpartum examinations.[8] Despite these recommendations, universal screening does not exist, and most providers do not screen for IPV. A national survey indicates that only 17 percent of prenatal providers routinely screen for IPV on the first visit, and only five percent screen on follow-up visits.[9]

LHDs play a critical role in the identification, intervention, and prevention of IPV. Addressing primary risk factors for violence among women of childbearing age will impact birth outcomes and a woman's overall well-being. Addressing IPV from a public health perspective involves more than setting up a crisis hotline or shelter for abused women. It also involves identifying risk and protective factors.

How Local Health Departments Address Intimate Partner Violence

LHDs have addressed IPV in a variety of ways—by training healthcare providers; increasing screening and referral rates; targeting health education and outreach efforts to at-risk populations; improving awareness among community members; and integrating IPV prevention and intervention strategies into existing LHD services. Screening and intervention activities can be integrated into well-woman care, into well-child care, and during family planning and prenatal care visits. The efforts of four LHDs to address IPV are described below.

Alaska State Department of Health and Social Services

A successful partnership between the Alaska Family Violence Prevention Project (AFVPP) and the Alaska Department of Health and Social Services has resulted in a coordinated response to IPV in Alaska. This collaborative effort involved Healthy Families Alaska, a home visiting program, as the point of intervention. Having frequent contact with families and knowledge of community resources allows home visitors to educate families about healthy relationships and how to recognize warning signs for abuse.

This partnership allowed for training and technical assistance on addressing IPV within the context of home visitation. AFVPP conducted and coordinated trainings that took place across the entire state. An important component of this program is the skills-based training offered to home visitors. The training focuses on building healthy relationships with clients, addressing real-life situations, and providing in-depth information about assessment and intervention strategies. In addition, home visiting staffs' needs and safety concerns are included in home visitation protocols in LHDs.

The Alaska Department of Health and Social Services recognizes that IPV is related to several social, emotional, and physical health concerns and plays a key role in facilitating a coordinated community response to IPV. Women who experience IPV, especially during pregnancy, have several interconnected needs. To address those needs, for example, the Fairbanks Municipal Health Department is co-located with a domestic violence shelter, home visitation programs, the Women, Infants and Children (WIC) program, and several other social service programs.

* AFVPP provides ongoing training and support to healthcare providers on the use of IPV screening tools and intervention strategies. These trainings include representatives from the wide spectrum of social and public health services, including WIC, public health nursing, tobacco cessation, health education, transitional housing, injury prevention, mental health, substance abuse, family planning, and local domestic violence shelters. Training goes beyond "Intimate Partner Violence 101" by getting all partners to collaborate. Provider trainings are made relevant to each entity at the table by emphasizing the interconnected nature of the issue. When WIC staff members are trained to do IPV screening, for instance, they are able to make the connection and see how IPV in a family could inhibit a pregnant woman from purchasing her WIC food items. Finally, bringing all community organizations together strengthens partnerships and increases collaboration between home visiting staff and agencies that address family violence.

Boston Public Health Commission

The Boston Public Health Commission (BPHC) serves a large, diverse urban community. During case interviews for an infant mortality review program, LHD staff identified significant gaps between women's health needs and the services received. Poor health prior to conception was linked to poor birth outcomes. BPHC used this information to learn more about women's health and to identify and address risk factors (e.g., violence) for women prior to their becoming pregnant. Based on interviews conducted by BPHC, women of reproductive age were not being screened and were not receiving information about IPV prior to pregnancy. To address this need BPHC designed and implemented the "Preconceptional Screening and Assessment Project."

* The main goal of the project is to increase the number of women identified at risk for IPV and ensure they receive educational material and access to resources prior to pregnancy. The project began with the development of a brief behavior risk screening instrument for preconceptional women. Since IPV frequently occurs with other behavioral risks, such as depression and substance use, the tool was designed to assess multiple behaviors and risk factors. The comprehensive health assessment tool was designed to be used every time a woman is seen and is given to all women of reproductive age, regardless of their pregnancy intentions.

BPHC's innovative strategy to address IPV during the preconception period relies on partnerships with the local community. BPHC oversees the screening protocol and implementation of this tool at several sites, including community health centers and local hospitals. The project was initially implemented in primary care settings. Risk assessment as a routine part of the primary care visit may help women feel more comfortable with the issue and, therefore, may make them more likely to disclose. Mental health case managers also administer the screening tool.

Training and technical assistance on the use of the tool is available for all providers. Training gives an opportunity for the providers to discuss their concerns and learn about community resources specific to the population served.

Multonomah County (OR) Health Department

Multonomah County, located in the northwest corner of Oregon, is the state's smallest county geographically but is the most populous in the state. The Multnomah County Health Department (MCHD), located in the city of Portland, serves both urban and rural areas. MCHD participated in a demonstration project funded by the Health Resources and Services Administration (HRSA) to reduce the incidence of IPV experienced by pregnant and postpartum women. The project was operated through MCHD's home visiting program and public health clinics. The project included client intervention, health provider training, and community collaboration. LHD staff worked with the Healthy Start Community Consortium to identify IPV as a contributing factor to poor birth outcomes. MCHD also targeted outreach and education activities to men in the community and worked with local coalitions of public and private healthcare providers addressing IPV.

As a result of the project, MCHD developed screening and intervention protocols. In place of a lengthy and intense screening questionnaire, providers are instructed to ask three simple questions: whether there is a history of violence; whether there is current physical or emotional violence; and whether the client needs or has a safety plan.

Each client that receives home visiting services from MCHD is screened for violence at least once during the prenatal period and at least once during the postpartum period. The client is also screened when significant life changes occur. Such changes might include a birth, death, job change, relationship change, or a move, all of which can cause additional stress, making it important to repeat screening during this time. Adopting a shorter and more frequent screening protocol has increased screening rates among those who receive home visiting services.

The required home visiting forms have a distinct place for violence screening. In order to increase universal screening, annual performance measures for the home visiting sites in the county now include violence screening. If a client screens positive for IPV, intervention includes culturally appropriate resources, emergency funds, safety plans and help in obtaining restraining orders, and individual case management. MCHD developed client education packets to address IPV in the context of larger safety messages for clients. These packets include general safety information, such as preparation for emergencies or disasters. Removing the stigma associated with IPV and putting violence in the context of overall safety may increase awareness and help some families discuss IPV as a safety concern.

MCHD has increased its staff's capacity to effectively provide accurate information and referrals that are culturally appropriate. A manual titled Improving the Response to Partner Violence was created for LHD staff. The training includes education on specific topics related to IPV, how to conduct screening and assessment (including effective interviewing skills), and technical assistance and support for individual cases. When training providers, MCHD emphasizes the importance of screening and helps providers understand that asking a woman if she is being hurt is an intervention in itself. Having this questioning come from a healthcare provider (who may be viewed as a person of authority), lets women know that violence is not normal or something they need to live with. If women are asked these questions frequently, they may disclose to their provider.

HRSA funding for the program ended in 2006. However, internal funding from the LHD was secured to support a violence prevention program supervisor and to ensure screening for IPV as a universal practice within the Early Childhood Services Division of MCHD. An internal task force was developed to design, implement, and advocate for future violence prevention efforts within the LHD.

Seattle/King County (WA) Public Health

Public Health – Seattle & King County (PHSKC) provides IPV screening, assessment, and education through the "Parent Child Health" (PCH) and the "Washington State First Steps Maternity Support Services" (MSS) programs. PCH, a program within PHSKC's Community Health Services division, provides leadership and coordination of all home-based, clinical, and community agency programs for pregnant and postpartum women and children. PCH developed the domestic violence screening and intervention project through a grant from the Department of Health and Human Services' Administration for Children and Families in 2003.

PHSKC is also the largest provider of the MSS program for pregnant and parenting women in Washington. PHSKC operates MSS through its eleven health centers and its satellite sites. This program helps low-income pregnant women get the health and social services they may need. These services are provided to promote positive health outcomes for pregnant women and their infants.

Multidisciplinary teams in the MSS program are made up of nurses, social workers, and nutritionists who are trained to screen for IPV. All clients are screened two times during pregnancy and once during the postpartum period. At the time of the screening, all clients receive education and information about risks for violence and stressors during pregnancy. The initial screening offers a chance to raise awareness about the prevalence and scope of IPV during pregnancy. Multiple screenings are conducted because clients are less likely to disclose initially. If a screening is positive for risk of IPV, a team member will conduct a brief safety assessment to identify areas of risk and will do immediate safety planning with the client. The entire process can be helpful in encouraging a woman who is experiencing violence to disclose and receive help.

PHSKC uses electronic charting to measure and evaluate client progress. The screening allows the health department to assess how much screening is being done and provides a measure of the prevalence of violence during pregnancy in King County. This method provides locally relevant data that can be used to seek funding sources for violence prevention programming and screening activities.

Partnerships have been at the forefront of PHSKC's efforts to address IPV during pregnancy. PHSKC has partnered with the Washington State Department of Health to create a training curriculum for healthcare providers. This training helps providers carry out universal screening by increasing their comfort with the issue and giving them clear guidelines and protocols. PHSKC provides technical assistance and clinical supervision to the social workers who assess for IPV. Supporting providers through this process is an important part of the training, especially when there is a lack of community resources.

* The next step for the partnership with the Washington State Department of Health includes promoting the training curriculum and expanding assessment efforts into other public health programs, such as family planning and primary care. Additionally, PHSKC would like to move beyond training individual providers to focus on the issue from a broader perspective: understanding how IPV impacts the health of a larger community.

The health department also collaborates with social service agencies (e.g., Child Protective Services) and community organizations (e.g., domestic violence shelters). This collaboration allows the LHD to address IPV more effectively. LHD staff members have established relationships and share resources with these entities. Clients who come to the LHD for services are sometimes referred to collaborating social services agencies and community organizations. The LHD also shares information provided by the social service agencies and community organizations with LHD clients. PHSKC representatives are also members of local councils and coalitions working to address IPV. These successful partnerships have made a significant difference in PHSKC's capacity to address this issue.

Challenges

LHDs face multiple challenges in addressing IPV. Viewing IPV from a broad public health perspective reveals that these challenges are present on individual, organizational, and community levels. Some of the most common barriers faced by LHDs are listed below.

Barriers to Developing Evidence Base and Identifying Data:

- There is a lack of evidence based intervention strategies for IPV.
- Available data on the number of pregnant women who experience violence are often incomplete.
- Data on the local level or for specific populations regarding IPV are lacking.
- IPV often is underreported.

Barriers to Provider Education and Training:

- Providers need enhanced training and education about the prevalence and consequences of IPV in order to feel more competent in assessing and intervening.
- Providers indicate that there is too little time to screen during visits.
- Providers may feel that the intervention is unlikely to change client behavior or the client will not be able to receive the help she needs.

Barriers to Promoting Screening and Assessment Tools:

- Providers may not recognize the importance of screening.
- Additional time, energy, and support are needed from LHD leadership to promote universal screening.
- Screening for IPV competes with other priorities and health education topics.
- Assessment tools for clinic settings may not be transferable to home visits.

Barriers to Open Communication with Clients:

- There are low rates of disclosing violence due to fear, feelings of shame, or embarrassment.
- Language barriers and lack of information about community resources are also impediments to disclosure.

Next Steps

LHDs have reasons to be optimistic when developing programs to address IPV among pregnant women. LHDs can work with community partners to identify venues for intervention and can be involved in both primary prevention (efforts to keep violence from occurring in the first place) and secondary prevention (intervening and responding to violence after it occurs).

Addressing the challenges in data and evaluation may be difficult, especially since IPV is likely to be underreported. LHDs can use Pregnancy Risk Assessment Monitoring System (PRAMS) data or collaborate with the state center for health statistics to gather and analyze data on the state level. Connecting with local law enforcement or emergency medical services for data-sharing agreements is another option. Although the evidence base is still lacking, screening methods and interventions for IPV continue to be researched and evaluated. As more effectiveness data become available, LHDs can use this information to plan and implement initiatives. LHDs can continue to evaluate the effectiveness of

their own screening and intervention methods, which will help with priority setting within the LHD and will help to identify, document, and disseminate the most successful approaches to IPV prevention.

Provider education and training are essential components of a comprehensive approach to IPV prevention. Commitment from providers is necessary, so LHDs can work to increase providers' level of comfort with addressing sensitive issues such as IPV and enhance staff's ability and confidence to provide appropriate information, referrals, and interventions. Providers need to understand the magnitude of the problem and learn how to best use resources that are available to women experiencing violence. LHDs need to establish strong referral networks, keep updated information on community resources, and continue to strengthen relationships with community partners such as shelters and advocacy organizations.

Screening for IPV among pregnant women needs to be seen as a priority within the LHD and community. Protocols for screening and intervention should be developed, and all LHD staff should be trained on their use. Having all who come into contact with women, whether they are social workers, physicians, public health nurses, or other healthcare or social service providers, know that screening is their responsibility makes it easier to promote universal screening within the LHD. Identifying IPV as a priority will also increase the likelihood that IPV screening will take place in settings such as family planning, primary care, prenatal care, and pediatric clinics as well as in WIC offices.

If universal screening protocols are not available, LHDs are still able to administer assessments, engage in safety planning, and provide clients with some resources. LHDs can create community resource guides or pocket reference cards with important phone numbers and information about area shelters or legal services. Any effort at screening and education is beneficial.

LHDs can begin to address IPV by researching assessment tools and finding one that is appropriate for their community. The screening tools used by the LHDs described in this brief were developed based on current literature, have been piloted and focus group tested, are culturally appropriate, and screen for emotional, physical, and sexual abuse. Additionally, they are part of standard protocols for addressing IPV.

Conclusion

LHDs and public health professionals play a critical role in preventing IPV during pregnancy. Although pregnancy represents a time of increased risk and vulnerability for violence, it also represents an ideal opportunity for prevention and intervention. Despite the many challenges, universal screening for IPV among pregnant women is feasible.

Coordinated, comprehensive approaches to address IPV during pregnancy are key. IPV is a multilevel problem that requires a multilevel response. Because IPV is linked with several harmful consequences for both mothers and children, LHDs must engage staff, providers, and community partners to view IPV prevention as a priority and to adopt standard screening policies and procedures. Doing so will improve maternal and child health outcomes.

End Notes

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