

AMCHP REPORT

Association of Maternal & Child Health Programs

CREATING AN INFRASTRUCTURE TO IMPLEMENT INTIMATE PARTNER VIOLENCE PREVENTION AND PERINATAL HEALTH PROMOTION

AMCHP-Family Violence Prevention Fund (FVPF) Final Project Report

December 2008



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Executive Summary

Intimate partner violence (IPV) is a pervasive problem in the United States. The effects of IPV on women's and perinatal health are significant. IPV can lead to a number of chronic health problems, including depression, alcohol and substance abuse, sexually transmitted diseases, and can limit the ability of a woman to manage other chronic illnesses and make choices about her health.¹ It can also lead to unintended pregnancy, rapid repeat pregnancy, pregnancy complications and preterm and low birth-weight babies. However, the opportunity to address and prevent IPV in health care settings is often missed. State Maternal and Child Health (MCH) programs, in partnership with providers and research and advocacy organizations, can create an infrastructure to adequately address IPV in health care settings. The availability of highly trained professionals, integrated partnerships, and quality services and resources is critical to addressing and reducing the occurrence of violence against women.

In this report, the Association of Maternal & Child Health Programs (AMCHP) and the Family Violence Prevention Fund (FVPF) discuss strategies to address IPV by increasing public awareness and public and provider education and training. This report also outlines a few of these innovative strategies, which emerged from the efforts of four states – Maine, Massachusetts, Missouri and New Mexico – as part of AMCHP's Safe Families Initiative.

The Safe Families Initiative helped states create systems-level changes by using a continuous quality improvement methodology and process. State mini-grants were awarded to help teams coordinate and conduct capacity-building activities based on their action plans. Over the last two years, the teams strived to ensure that systems and services were improved in order to provide women with the assistance they need to overcome and prevent further violence. By increasing the number of providers that were trained on screening for and addressing intimate partner violence, improving screening tools, enhancing public awareness, and creating integrated partnerships, these states changed the way IPV, domestic violence (DV), and sexual assault (SA) are addressed and prevented in communities.

It is our hope to link other states with the screening tools, resources, trainings, and public awareness and partnership strategies that Maine, Massachusetts, Missouri and New Mexico developed and improved throughout this initiative.





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OVERVIEW

It is estimated that between 3 and 5.3 million women in America are physically abused by their husbands or boyfriends each year.^{2,3} For many women it is fatal: on average, more than three women are murdered by their husbands or boyfriends in the United States every day. In addition to the immediate physical trauma caused by abuse, intimate partner violence (IPV) contributes to a number of chronic health care problems including depression, alcohol and substance abuse, sexually transmitted infections, unintended pregnancy, rapid repeat pregnancy, pregnancy complications and preterm and low birth-weight babies. The Center for Disease Control and Prevention (CDC) finds that women who have experienced partner violence are at significantly greater risk for heart disease, stroke, asthma, arthritis, heavy drinking and risky sexual behaviors than women who have not experienced partner violence.⁴ Violence also limits a woman's ability to manage chronic illnesses such as diabetes and hypertension.

In 2006, a year that marked the reauthorization of the national Violence Against Women Act and the 10th Anniversary of the National Domestic Violence Hotline, leaders from across the United States convened to discuss the development of bold new approaches to measurably reducing domestic violence in America by 2017. As a result, some key reoccurring strategies emerged for reducing interpersonal violence over the next 10 years, which included public awareness and public and provider education and training. This report outlines a few of these innovative strategies, which emerged from the efforts of four states – Maine, Massachusetts, Missouri and New Mexico, as part of the Association of Maternal & Child Health Programs' Safe Families Initiative. These states strived over the last two years to change the way intimate partner violence, domestic violence and sexual assault are addressed and prevented in communities nationwide. From training providers to improving screening tools, each state aimed to increase awareness and education about an issue that greatly impacts women, children and families.



The National Maternal and Child Health Bureau (MCHB) Title V legislation directs states to conduct a maternal and child health needs assessment every five years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and children with special health care needs.⁵ While there is not a National Title V priority measure for violence in maternal and child health populations, States can select seven to 10 additional priorities for focused programmatic efforts over the succeeding five years. Nationally, seven states and territories (Guam, Kentucky, Missouri, Nevada, New Mexico, Texas and Washington) have violence as a priority measurement and 10 states and territories (Alaska, California, District of Columbia, Guam, Massachusetts, Missouri, Nevada, New Mexico, New York, Texas) have violence as a priority need. Three of these states — Massachusetts, Missouri, and New Mexico, participated in the Safe Families Action Learning Lab (ALL) and also have an additional priority need that falls into these categories. AMCHP, together with the Family Violence Prevention Fund (FVPF) focused on IPV in the Safe Families ALL in order to promote safe motherhood- in this case, by preventing maternal and preconception violence injury, related conditions (unintended pregnancy, sexually transmitted infections depression, substance use, etc) and death. In addition, IPV was recognized by member states as an interest and it meets AMCHP's women's health agenda goal to address chronic conditions and injury.

INTEGRATING MCH AND INTIMATE PARTNER VIOLENCE: USING A PREVENTATIVE PUBLIC HEALTH APPROACH

Overview of the Action Learning Lab (ALL)

The Association of Maternal & Child Health Programs (AMCHP) is a national non-profit organization serving the directors and staff of state and territorial programs of maternal and child health (MCH) and children with special health care needs (CSHCN). The Family Violence Prevention Fund (FVPF) works to prevent violence within the home and in the community, and to help those whose lives are devastated by violence. With



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funding from the CDC, AMCHP partnered with FVPF in 2006 to accept four state teams for participation in the Safe Families ALL. The Safe Families ALL brought together multidisciplinary partners from each state to develop and implement projects to address IPV and health disparities in their states. AMCHP has conducted Action Learning Labs (ALLs) with its members since 1996 on a range of topics, including Medicaid and child health insurance reforms, smoking cessation, mother-to-child HIV transmission and perinatal disparities. In general, an ALL brings diverse teams together to work on emerging issues in MCH, to create new approaches to ongoing issues, to build

knowledge and use of promising practices, and to establish partnerships that may result in more enduring positive health outcomes for families. The ALL is based on continuous quality improvement methodology, a planning and improvement process that has proven effective in making systems-level changes. State mini-grants were awarded to help teams coordinate and conduct capacity-building activities related to their Safe Families ALL action plans. (See below for a description of the technical assistance and training provided by the Family Violence Prevention Fund).

SNAPSHOT OF TECHNICAL ASSISTANCE AND TRAINING TOOLS PROVIDED BY THE FAMILY VIOLENCE PREVENTION FUND TO STATES

- ▶ Conducted a two-day training for ALL participants in October 2006
- ▶ Conducted quarterly group technical assistance calls to ALL Teams
- ▶ Conducted one-on-one technical assistance calls as needed to monitor and assist the implementation of each team's action plans
- ▶ Offered in-person technical assistance site visits in ME, MA and NM
- ▶ Presented at AMCHP's annual conference on the Safe Families Initiative in March 2008
- ▶ Planned and led in-person strategy session for Safe Families teams in March 2008
- ▶ Conducted training for every DPH funded family planning program in MA reaching over 170 staff at 75 sites throughout 2007
- ▶ Conducted two follow-up trainings in September 2008 for Family Planning directors in MA
- ▶ Conducted two trainings for home visitation programs in September 2008 in MA
- ▶ Held a one-day training at a statewide meeting of School Based Health Programs in MA
- ▶ Conducted a training with domestic violence and sexual assault advocates on statewide mandatory reporting and confidentiality information in NM
- ▶ Hosted two trainings for representatives from WIC, Families First, Family Planning and First Born Programs in NM
- ▶ Helped develop a survey regarding screening practices and knowledge and attitudes of providers and referral patterns in NM
- ▶ Conducted one training for public health department leaders in Maine



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THE SAFE FAMILIES INITIATIVE: A COLLABORATIVE APPROACH TO REDUCING VIOLENCE

AMCHP and FVPF awarded up to \$5000 to four states, Maine, Massachusetts, Missouri and New Mexico, to coordinate and conduct internal capacity-building activities (e.g., skills training, materials development, resource identification, etc). All activities were based on objectives outlined in their Safe Families ALL action plan. Each awarded state provided a comprehensible action plan, which included an estimated budget of expenses, definitive roles for team members, evidence of collaboration, an evaluation plan and a feasible timeline of activities.

State mini-grant activities were designed to result in new or improved:

- ▶ Partnerships across key agencies and/or community groups that can impact violence and disparities;
- ▶ Provider or public awareness of existing resources and effective interventions to address family violence; and
- ▶ State capacity to collect, analyze or share relevant violence and disparities* data and/or tools to screen for violence in clinical or MCH program settings or to assess system capacity to address violence and disparities.

Key Accomplishments of the Safe Families ALL Teams:

- ▶ Trained over 500 WIC staff in the state of Massachusetts.
- ▶ All of the Massachusetts Department of Public

TEAM PROFILES			
STATE	PARTNERS	DV AND SA FACTORS ADDRESSED	STRATEGIES
Maine	Domestic Violence and Sexual Assault Coalitions Non-profits Government Agencies Department of Health and Human Services Universities	Mental Health/Depression/ Behavioral Health Health Disparities Minority Populations Immigrant/Refugee WIC Population HIV Prevention and Treatment	Provider Trainings Data Collection Screening Tool Adaptation and Development
Massachusetts	Domestic Violence and Sexual Assault Coalitions Hospitals Community Health Centers Government Agencies	WIC Populations Family Planning Programs	Provider Trainings Statewide Policy Reform Toolkit development
Missouri	University Domestic Violence Agency	Mental Health/Depression/ Behavioral Health Health Disparities	Provider Trainings Community Forum Public Awareness Campaign
New Mexico	Government Agencies Office of the Governor Non-Profits Department of Health	WIC Home Visitation Midwifery Program Alcohol and substance abuse	Provider Trainings Survey MCH providers

*For the purpose of this mini-grant initiative, disparities are defined as a health differences in perinatal outcomes due to social, economic and environmental factors.



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Health-funded family planning programs (over 170 staff at 75 sites across the state) were trained on screening for lifetime exposure to violence.

- ▶ Changed policy on WIC training and service provision in Massachusetts.
- ▶ Trained professionals and advocates to improve identification and referral rates of domestic violence in health settings in Maine.
- ▶ Evaluated and improved a statewide assessment questionnaire in New Mexico.
- ▶ Advised CDC in adopting recommended changes to PRAMS (Pregnancy Risk Assessment Monitoring System) data collection for states to optionally add to their state PRAMS survey.

violence, child abuse and neglect and sexual assault services and prevention efforts; and

- ▶ Developed systems for addressing IPV that include public health monitoring, prevention and intervention.

Maine's activities included: 1) developing, expanding, and strengthening partnerships between State Title V Agency, State public health department, and local community health programs with the Governor's Commission on Domestic Violence and Sexual Assault, the Violence Intervention Project, statewide and local domestic violence (DV), sexual assault (SA), and intimate partner violence (IPV) prevention efforts and resources; 2) creating awareness of intimate partner violence, domestic violence, and sexual response as public health issues. Promote public health's role in state and local prevention efforts and screening initiatives; 3) further developing an agenda and action plan for public health to work collectively with partners on developing and delivering training on cultural competency while discerning ways in which to address perinatal health disparities related to DV, SA and IPV with minority and underserved populations in Maine.

In November 2007, the team trained various public health professionals across the state to help them learn more about sexual and domestic violence. This group of professionals included community level domestic violence (DV) and sexual abuse (SA) educators/providers, public and community health providers, and the staff at Federally Qualified Health Centers. These train-the-trainer sessions focused on screening for domestic violence, sexual abuse, and intimate partner violence in rural, community and public health settings. It also encompassed cultural and linguistic competency training to address perinatal health disparities related to DV, SA and IPV among rural, minority and underserved populations. Lastly, the training provided the group with tools to help them communicate more effectively with their clients on these issues.

To effectively reduce perinatal disparities in IPV and SA, Maine addressed other factors such as mental health/depression/behavioral health, health



STATE MINI-GRANT PROFILES

The following profiles provide a snapshot of the work conducted by each of the four teams, which include a project overview, additional factors addressed, partnerships created, and outcomes achieved.

MAINE

Project Overview

The goal of the Maine team was to reduce perinatal health disparities by addressing intimate partner violence (IPV) and sexual assault (SA) among minority, rural and underserved women of reproductive age in Maine. The team's long-term outcomes for achieving this goal included:

- ▶ Increased awareness of IPV as a public health issue;
- ▶ Instituted a change of culture in Maine to demonstrate that violence is not an option;
- ▶ Integrated family violence prevention components, with training, technical assistance, awareness, and access to resources available in multiple public health programs, education settings, social service and support programs;
- ▶ Established public health linkages to state and local family



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disparities, minority populations, immigrant/refugee populations, the WIC population, and HIV prevention and treatment. The Maine team said, "for the most part, these factors were all intentionally addressed due to our understanding and the data around the long-term impacts of sexual and domestic violence, as well as the risk factors for experiencing this violence. This was addressed through a training we conducted to help public health professionals such as WIC works, family planning professionals, HIV prevention professionals, public health nurses and others identify, screen for and provide resources to victims/survivors of domestic and sexual violence. We also worked to show the connection between SV/DV and the work that professionals do on a daily basis and why it is important to them."

While implementing activities, the team struggled with obtaining accurate data on reporting rates and prevalence data from the state. However, one of the subcommittees from the partnership is currently in the process of developing a Surveillance Plan for Maine to help increase the ways in which data is collected. The team is hopeful this tool will be available soon.

Partnerships

The Maine team formed diverse partnerships with coalitions (Maine Coalition Against Sexual Assault, Maine Coalition to End Domestic Violence, Violence Intervention Partnership), non-profits (Boys to Men, Physicians for Social Responsibility, Maine Primary Care Association), government (Office of Substance Abuse, Department of Education, Office of the Attorney General), offices in Department of Health and Human Services/Bureau of Health, and universities (University of Southern Maine, University of Maine). The team said that, "obstacles in forming these partnerships included being able to ensure

all (of the partners') voices and perspectives were given sufficient priorities during training and outreach. Each partner brought a great deal of expertise to the table and helped make many more statewide connections."



"It is essential to cast the net far and wide and bring as many different disciplines to the table...the collective expertise and connections that can be made beyond the meetings are invaluable... (these) partnerships formed have long-term value."

Member of the Maine Safe Families team

Outcomes

The Maine team created a statewide action and surveillance plan to address domestic violence and sexual abuse. Throughout their activities, the team worked to increase awareness and knowledge of cultural competence and techniques to foster disclosure within identified systems of care. The Maine team translated their findings for state health agency staff, local health agency staff, non-governmental public health organizations, and healthcare providers. As a result the team found that, "The partnerships developed at this table are likely to continue long beyond this specific project and have really helped demonstrate the many ways that sexual and domestic violence prevention and intervention need to be done at what was once considered a 'peripheral' level." Other accomplishments spearheaded by the Maine team include: 1) voluntary changes have been or are likely to be instituted within the healthcare and/or social service delivery system; 2) providers and advocates were trained to increase screening rates and/or referral rates; 3) providers were trained and recommended screening questions were provided to training participants; 4) while post-training survey results are still being compiled, screening and referral rates have improved.

MASSACHUSETTS

Project Overview

The goal of the Massachusetts team was to build the knowledge and capacity of state-level MCH professionals and their community partners in order to integrate family violence prevention, assessment and





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intervention into community-based programming. Massachusetts activities focused on building the knowledge-base and capacity within family planning services statewide to screen and respond to family violence, implementing technical assistance activities and staff trainings, and working with the state and local WIC and Family Planning programs to develop an institutionalized expectation for trauma-informed practice across service systems that serve the MCH population.

One of the major obstacles experienced by the Massachusetts team was a lack of time and money. However, many opportunities existed among their state systems of care to provide needed interventions and to institutionalize trauma-informed practice. As with any project, staff time and availability to devote to the project (in family planning and beyond) was limited. However, the philosophy and approach of the Massachusetts Safe Families Project Team was to explore possibilities across disciplines to integrate the work of family violence prevention/ intervention into MCH programming.

Partnerships

The Massachusetts team partnered with staff from the FVPF; staff from the state family planning, early intervention and WIC programs based within the state department of public health; staff from the Department of Transitional Assistance and Department of Children and Families; staff from the state coalition, Jane Doe Inc.: The Massachusetts Coalition Against Sexual Assault and Domestic Violence; as well as multiple colleagues coordinating domestic violence programs within health care settings (Boston hospitals and community health centers).

Outcomes

Provider Trainings

As a part of the project, the Massachusetts team leader worked with the state DPH WIC staff to institutionalize their work addressing domestic violence. The Massachusetts WIC Program serves over 130,000 families a year, which includes over 30,000 women and 100,000 infants and children. Overall, WIC services are provided at over 130 sites statewide based within 35 local programs. As a result of the Safe Families ALL, the Massachusetts team significantly improved their WIC programs response

to intimate partner violence and sexual assault. This will be achieved through the following:

- ▶ Conduct Domestic Violence Trainings twice a year for all new WIC staff;
- ▶ Implement routine domestic violence screening of WIC participants; and
- ▶ Provide support and consultation for local WIC programs on domestic violence.

Family Planning

In 2007, a series of 10 trainings were conducted by FVPF staff at individual family planning sites across the state. Over 170 staff from 12 family planning agencies (based at a total of 75 sites) was trained. The training included: data on the connections between lifetime exposure to violence and poor reproductive health; survivor stories; screening "how-to's" individually tailored by clinical visit type; discussion on how to address disclosures and victimization with patients and as well as among family planning staff; and local community resources. Community partners were invited from rape crisis centers, domestic violence resources, and other intimate partner violence resources (e.g., shelters, sexual assault nurse examiners, etc.) to help educate family planning agencies on community resources and to enhance the referral relationship.

A final training was held in September 2008 and offered to staff of all the local family planning programs. Participants were reminded about the connections between violence and reproductive health, offered lessons learned from the ongoing intervention study in California, and worked with participants to develop their own scripted tools that feel comfortable and helpful in their clinical contexts. The trainings have strengthened local family planning program's relationship with their local rape crisis centers and domestic violence programs. In addition, discussion has begun at the state level and at some of the local programs to start some pilot data collection on screening and disclosure rates.

Screening Tool Adaptation and Development

The Massachusetts team worked closely with FVPF staff to revise the "Family Violence and Reproductive Health Program Assessment Tool" for family planning programs.



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Initial data was collected for all of the state funded family planning programs and the team plans to do a follow up assessment using the same tool, data will then be compared with the original baseline data.

In consultation with staff of the FVPF, the Massachusetts Safe Families data committee advocated along with other states for three new questions to be added to the core questions on PRAMS (Pregnancy Risk Assessment Monitoring System). The questions will include collecting information on:

birth control sabotage, limited access to prenatal care resulting from IPV and the impact exposure to abuse has on pregnancy and post pregnancy. Subsequently, the three questions were tested and approved by CDC to be a part of the 2009 set of "standard" questions for states to optionally add to their survey.

The FVPF, the Massachusetts Department of Public Health's Family Planning Program and the Domestic Violence Intervention Program (DVIP) worked to create a toolkit of materials that could be used by family planning agencies for implementing scripted sexual and domestic violence screening. The toolkit consisted of an array of prompts that remind providers to discuss sexual and domestic violence with all their clients and offer language that helps providers bring up the topic of violence in a sensitive way. Different tools may work for different providers and different clients in varied clinical contexts. This toolkit is highlighted on pages 12 and 14 in this report.

Policy and Protocol Development and Improvement

An additional component of the Massachusetts team work was the revision of the state family planning program standards to include screening for lifetime exposure to sexual and domestic violence. Through this process the state family planning staff is in the process of developing new systems for contract oversight and creating tools for site visits which include more focus on violence related issues.

In addition, the state level family planning program has currently drafted a proposal to further this work beyond the life of the Safe Families ALL. The goal for the program is to:

- ▶ Integrate sexual assault and domestic violence screening and interventions into family planning clinical settings in a way that is sensitive to the repercussions of lifetime exposure to violence;
- ▶ Identify and assist family planning clients who have experienced recent or past SA/DV; and
- ▶ Support staff as they provide screening, intervention, and care.

MISSOURI

Project Overview

The goal of the Missouri team was to increase provider knowledge and training for screening and referral services for domestic violence and perinatal health. Missouri's activities included improving and increasing the capacity of current programs, providing trainings, and increasing awareness by promoting public awareness initiatives. For example, DV and SA trainings were provided for multiple providers such as home visitation nurses, Alternatives to Abortion providers and participants attending the Sexual Assault Prevention Conference in August 2007. The team also focused on increasing the knowledge of home visitation programs and increasing referral for at-risk mothers to programs (see below) Missouri partnered with throughout the project year. They saw this as integral to effectively reduce perinatal disparities in IPV and sexual assault in their state.

"Participation in the Safe Families Action Learning Lab was a valuable experience for the Missouri team. Having access to national experts was a tremendous opportunity as we crafted our planning for the state. Prior to this experience, the state pulled together local and state partners to address the issues of domestic violence and child abuse and neglect but in isolation of one another. Through this Action Learning Lab, we pulled together all programs and partners addressing interpersonal violence and now have a state team that is much richer in resources and expertise."

--Melinda Sanders, MSN, RN, Missouri Title V Director and Section for Healthy Families and Youth Administrator



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Partnerships

The Missouri team consisted of members from the Missouri Department of Health and Senior Services, the Office of Minority Health, Missouri KidsFirst (child advocacy network), Children's Trust Fund, Department of Social Services and Mercy Health Plan and the Rose Center. The Missouri team also partnered with the University of Missouri Columbia- Sinclair School of Nursing; the Rose Brooks Center, a domestic violence agency; and various home visitation programs such as the Missouri Community Based Home Visiting Program, the Sinclair School of Nursing DOVE project, and Building Blocks of Missouri. Each of the home visiting programs works to address IPV and health disparities by providing home visits and case management via nurses and paraprofessionals to families at risk for infant mortality, morbidity, and child abuse or neglect.

Outcomes

Trainings

The Missouri state team conducted a Domestic Violence Training program for 57 staff from the Missouri Department of Health and Senior Services' (DHSS) Home Visiting and Alternatives to Abortion program. The home visiting program collaborates with the University of Missouri-Columbia on the DOVE (Domestic Violence Enhanced Home Visiting Intervention) project. The program objectives included enhancing awareness of the relationship between domestic violence and health and safe parenting, addressing issues of domestic violence in a home visitation setting, and encouraging the development of written protocols and collaborations for domestic violence situations. The Missouri team increased knowledge of home visitors of domestic violence screening and increased referral of moms to the DOVE project. Partnerships that were formed have long-term value, including Sinclair School of Nursing working on the DOVE project.

The Missouri Safe Families team also provided training at the Sexual Assault Prevention Conference – The Spectrum of Prevention, August 6-8, 2007. The training, *Screening for Domestic Violence in a Healthcare Setting: Ideas, Implementation and Importance*, was presented by a member of the Safe Families team. There were 152 participants in the conference, primarily sexual assault

and domestic violence advocates, nurses, social workers, and administrative staff from shelters and hospitals. Participants were trained on screening techniques for domestic violence in a healthcare setting.

Public Education Campaigns and Community Forums

The team also worked to increase awareness around domestic violence and sexual assault through initiatives such as Denim Day and the Healthy Marriage Initiative of February 2008. Denim Day has been internationally celebrated since 1999 in protest of an Italian High Court ruling that overturned a rape conviction because the victim was wearing jeans. To that end, the Missouri team promoted and disseminated the Denim Day toolkit produced by the Missouri's Department of Health and Senior Services' Office on Women's Health. The toolkit contained a CD with all the materials needed to plan and implement a Denim Day event; a bookmark, poster and flyer; and the Denim Day lapel pin.

NEW MEXICO

Project Overview

One of the primary goals for the New Mexico team was to ensure that all WIC staff were trained on domestic violence and equip them with the necessary tools in order to talk with clients about domestic violence and give each staff member a resource booklet. Prior to this training, WIC staff had never been trained on domestic violence. In addition to these trainings, the New Mexico team worked to improve:

- ▶ Partnerships across key agencies and community groups to impact violence and disparities.
- ▶ Provider and public awareness of existing resources and effective interventions to address family violence.
- ▶ State capacity to collect, analyze or share relevant violence and disparities data.
- ▶ Tools to screen for violence in clinical or MCH program settings or to assess system capacity to address violence and disparities.

Like the other teams, New Mexico encountered a few barriers as they implemented project activities. In the original partnership, there was lack of team stability



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due to staff turnover and it was also difficult gaining the support of all Family Health Bureau staff. However, after participating in a training on domestic violence, the Family Health Bureau staff recognized the importance of collaborating among programs to successfully address the issue of IPV. As a result of the training, the staff was more aware about the importance of domestic violence training. The trainings demonstrated the need for Directors to work together to implement successful multilayered programs.

Partnerships

The New Mexico team partnered with Maternal Health, the Midwifery Program Manager, the Office of Injury Prevention, New Mexico Legal Aid, and the Domestic Violence Czar in the Office of the Governor.

Outcomes

The New Mexico state team conducted training with domestic violence and sexual assault advocates statewide on new reporting and confidentiality information. The team trained staff from WIC, family planning and perinatal health organizations. The training provided insight into what was and what wasn't working for providers. The New Mexico team surveyed screening practices and knowledge and attitudes of providers and referral patterns and found that their screening questionnaire, "Violence, Alcohol, Substance Use, Tobacco Use" (VAST) was not being used, and are now adapting it accordingly. Some participants in the training expressed their concerns with the previous VAST screening tool. They indicated that the questions made them feel uncomfortable, or under-qualified. The New Mexico Safe Families team lead will sustain the project's efforts by continuing to send updates and materials to WIC nutritionists throughout the state.

"The Safe Families ALL has allowed for better data and programming exchange between statewide maternal and child health and violence prevention agencies."

– Member of the New Mexico Safe Families team.

Identifying the Gaps

As the project came to a close in September 2008, the state teams identified common themes and important gaps that need to be filled in the area of intimate partner

violence. One of the most pervasive themes that arose was the need for interventions to address both perinatal depression/post partum depression and domestic violence as a collective issue. All of the states indicated that when being abused by her partner, a woman is more than likely suffering from mental health issues such as depression. The states also indicated a need assistance developing a good strategy to provide trauma informed care that incorporates assessment for substance abuse and mental health issues together with violence without diluting the response to either issue. The following factors were also identified as critical to address to make an effective impact on reducing domestic violence and sexual assault:

- ▶ Additional funding to support MCH efforts to adequately address this issue
- ▶ Stronger national data collection on this issue (i.e. in PRAMS, YRBS etc.)
- ▶ National Title V measure specific to violence
- ▶ Mental health/depression/behavioral health need of victims of violence
- ▶ Targeting populations who have higher rates of domestic violence health disparities
 - Minority populations
 - Immigrant/refugee populations
- ▶ WIC populations
- ▶ HIV prevention and treatment
- ▶ Underreporting and issues with data collection
- ▶ Access to health care and services

IMPLICATIONS FOR PUBLIC HEALTH SYSTEMS

Over a period of two years, the Safe Families state teams worked within their communities to effect change with providers, the public and other health professionals regarding domestic violence, intimate partner violence and sexual assault. They created trainings, programs and materials that would help shift how these issues are viewed, addressed and prevented. The efforts of these states also effected change within some of our public



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health systems such as enhancing the PRAMS (Pregnancy Risk Assessment and Monitoring System) survey and lending a voice to the creation of a reproductive health toolkit used by FVPF with providers. Another one of the most significant developments that stemmed from the work of the Safe Families initiative was the creation of a reproductive health tool kit. These specific systems changes will alter how IPV, DV and SA are addressed in public health systems. The PRAMS improvements and reproductive health toolkit are highlighted below.

PRAMS Improvements

The FVPF worked closely with each of the four states to submit proposals to CDC to expand the PRAMS questionnaires to include three new questions on domestic violence. The questions would focus on collecting information about birth control sabotage, limited access to prenatal care resulting from IPV and the impact exposure to abuse has on pregnancy and post pregnancy. Subsequently, the three questions were tested and approved by CDC to be a part of the 2009 set of “standard” questions for states to optionally add to their survey. The questions are listed below:

Z7. During the 12 months before your new baby was born, did you miss any doctor appointments because you were worried about what your partner would do if you went? No Yes

Z8. Before you got pregnant with your new baby, did your husband or partner ever try to keep you from using your birth control so that you would get pregnant when you didn’t want to? For example, did he hide your birth control, throw it away or do anything else to keep you from using it? No Yes

Z9. During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way?
For each time period, circle **Y** (Yes) if it has happened to you or circle **N** (No) if it has not.

- | | | |
|---|----------|----------|
| a. During the 12 months before I got pregnant | N | Y |
| b. During my most recent pregnancy | N | Y |
| c. Since my new baby was born | N | Y |

Reproductive Health Toolkit

One of the most significant developments that stemmed from the work of the Safe Families initiative was the creation of a reproductive health tool kit. The lessons learned from the Safe Families ALL truly helped inform a new direction for how the FVPF trains reproductive health care providers to assess for and respond to violence and informed the reproductive health field on a national level. The FVPF has since expanded the traditional definition of IPV to include an initial focus on reproductive control in the relationship. Reproductive control is defined as intentionally exposing a partner to STIs, attempting to impregnate a partner against her will, and threats or acts of violence if the partner does not comply with the perpetrator’s wishes regarding the decision whether to terminate or continue a pregnancy. This approach has since been adopted by Planned Parenthood Federation of America – who revised their national medical guidelines to require that family planning providers in each of their sites address reproductive coercion and violence.

FVPF now recommends that providers start with an assessment of reproductive coercion and then move to follow up questions on physical violence and safety. For example:

- ▶ Has you partner ever tried to get you pregnant when you didn’t want to be?
- ▶ Does your partner ever make you have sex when you don’t want to?
- ▶ Does you partner ever put your health at risk by forcing you to have sex w/o protection?

FVPF has found that providers who have been trained using this new approach indicate they are significantly more comfortable approaching domestic and sexual violence through the reproductive control lens since it is more applicable to their practice and to their patients’ visit.

FVPF, with support from the Department of Health and Human Services, created the tool kit specifically for reproductive health providers to help them integrate this new approach. The tool kit includes:

- ▶ Patient safety cards with messages about reproductive coercion;



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- ▶ Pregnancy wheels: with prompts for providers to ask about reproductive coercion;
- ▶ Posters for reproductive health care settings;
- ▶ Assessment tools to evaluate and monitor the impact of changes in your clinic;
- ▶ Presentations for those who want to conduct training in their setting;
- ▶ Fact sheet on Reproductive Health and Violence;
- ▶ Annotated bibliography of research on violence and reproductive health; and
- ▶ Prompts for how to assess for violence and coercion when patients come in for HIV testing, pregnancy testing, Emergency contraception or annual visits.

These materials are currently available through the National Health Resource Center on Domestic Violence and on AMCHP's website at <http://www.amchp.org>. They are also being formally evaluated in an NIH funded study conducted in reproductive health clinics in California.

Conclusion

Domestic violence, intimate partner violence and sexual assault all have a profound impact on the health and well-being of a woman. The availability of highly trained professionals, quality services and resources is critical to reducing the occurrence of violence against women. Towards that end, Maine, Massachusetts, Missouri and New Mexico strived over the last two years to ensure that systems and services were changed to provide women with the assistance they need to overcome violence. By increasing the number of providers that were trained on domestic violence, improving screening tools, enhancing public awareness and creating integrated partnerships, these states changed the way IPV, DV and SA are addressed and prevented in communities nationwide.

Although the project has ended, AMCHP will continue to highlight and maximize the work of the state teams through sharing promising practices, disseminating state materials and presenting on the work of the states at various conferences. In addition, AMCHP and FVPF are continuing to partner to further address the issues of

DV, IPV and SA. It is our hope to link other states with the screening tools, resources, trainings and public awareness and partnership strategies that Maine, Massachusetts, Missouri and New Mexico developed and improved throughout this initiative.

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Endnotes

- ¹ Get the Facts: Domestic Violence and Health Care : <http://endabuse.org/resources/facts/HealthCare.pdf>
- ² Intimate Partner Violence Overview: <http://www.cdc.gov/ncipc/factsheets/ipvoverview.htm>
- ³ Get the Facts: Domestic Violence and Health Care: <http://endabuse.org/programs/display.php3?DocID=25>
- ⁴ CDC MMWR weekly: 57(05) 113-117. February 8, 2008
- ⁵ Maternal and Child Health Bureau Title V Program Data: State Priority Needs: <https://perfddata.hrsa.gov/mchb/mchreports/Search/program/prgsch01.asp>

Association of Maternal & Child Health Programs

2030 M Street, NW, Suite 350
Washington, DC 20036
(202) 775-0436

www.amchp.org

