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Innovative Strategies to Facilitate Safe Assessment and Intervention for Intimate Partner Violence During a Pandemic and Beyond

Janet Carey Guarino

ABSTRACT: The COVID-19 pandemic has made it necessary to find innovative strategies that facilitate safe, private assessment and intervention for intimate partner violence (IPV). IPV is a major source of morbidity and mortality, with women experiencing a lifetime prevalence rate of 22%. Screening pregnant individuals for IPV during the COVID-19 pandemic became critical because a 20% rise in IPV during the pandemic has been estimated. A multidisciplinary stakeholder panel created a process using technology to address this concern. An infographic poster with IPV screening questions and a Quick Response (QR) code was displayed in bathrooms in the perinatal service area. The infographic allowed respondents to signal a safety concern, launching an individualized plan of care to address their needs privately. The pandemic has highlighted how much work needs to be done to ensure that people who experience IPV continue to obtain access to support and health care.

doi: 10.1016/j.nwh.2021.05.007

Accepted May 25, 2021; published online July 14, 2021

KEYWORDS: abuse, COVID-19, health information technology, intimate partner violence, IPV, pandemic, perinatal, QR code, safety

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Intimate partner violence (IPV) is any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship (Ramaswamy et al., 2019; World Health Organization, 2012). IPV is perpetrated by someone who is, was, or wishes to be involved in an intimate relationship and aims to establish control of

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CLINICAL IMPLICATIONS

- The COVID-19 pandemic has made it necessary to find innovative strategies to facilitate safe and private assessment and intervention for intimate partner violence (IPV).
- Economic stress and social isolation are risk factors for IPV and make screening of pregnant individuals for IPV during the COVID-19 pandemic a priority.
- An infographic poster with IPV screening questions that also displays a Quick Response (QR) code and text number can be developed and displayed in bathrooms in the perinatal area.

one partner over the other (American College of Obstetricians and Gynecologists, 2012). This violence can be physical and may include actions such as hitting, shaking, or choking. It can also be sexual, including forced sexual intercourse or reproductive coercion. More than 10 million U.S. women have reported an intimate partner who interfered with their plans for preventing pregnancy by refusing to wear a condom or by controlling their birth control medications (Centers for Disease Control and Prevention [CDC], 2020). Finally, IPV can manifest as psychological or emotional violence, including stalking and repeated harassment (CDC, 2020; Ramaswamy et al., 2019).

IPV affects people of every race, gender, age, ethnicity, and socioeconomic group, but it has a disproportionate effect on communities of color and other marginalized groups (Evans et al., 2020). Some risk factors for IPV include having low income, residing in isolated areas, having minimal education, and being pregnant (Alhusen et al., 2015; Association of Women's Health, Obstetric and Neonatal Nurses, 2019; Bianchi et al., 2016).

IPV is a violation of a person's human rights and is a preventable public health problem that affects 1 in 3 women in the United States during their lifetime (CDC, 2020). The estimated annual rate for pregnant women reporting IPV is 22% (Ramaswamy et al., 2019); however, it is assumed that this number is underestimated (Alhusen et al., 2015) and that individuals may not disclose their experiences if health care providers do not ask specifically about safety and violence (Bianchi et al., 2016). In addition to physical injury and death, people who experience IPV in their lifetimes are more likely to experience chronic physical and mental health problems, including irritable bowel syndrome, chronic pain, sleep disturbances, and chronic headache (Dicola & Spar, 2016; Smith et al., 2017). Violence during pregnancy has been associated with late or absent prenatal care, intrauterine fetal growth restriction, fetal loss, and premature labor and birth (Breiding et al., 2014; Devries et al., 2010). These life-threatening global health problems have immediate and long-term impacts for maternal and neonatal health (Devries et al., 2010).

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IPV and Pregnancy

Pregnancy provides a unique opportunity to develop strong provider–client relationships because of the nature of frequent encounters with health care providers. Building trusting relationships with pregnant people during routine prenatal visits can facilitate assessment for violence during and after the pregnancy (Deshpande & Lewis-O'Connor, 2013).

Health care providers are educated in the possibility of violence as an underlying factor in a person experiencing poor health during pregnancy and are prepared to assess for signs and symptoms of abuse by an intimate partner. Health care providers play an essential role in diminishing the cycle of abuse for people experiencing IPV by reviewing available prevention, offering support, and providing appropriate referral options (Ramaswamy et al., 2019). This screening process needs to be universally executed and should occur only in confidential settings (Association of Women's Health, Obstetric and Neonatal Nurses, 2019).

The Context of a Pandemic

Although IPV has long been a public health issue, the COVID-19 pandemic presented additional barriers for providing safe, private health care for women. In Massachusetts, where this work occurred, the governor called for business closures, issued stay-at-home orders for nonessential workers, and mandated physical distancing and masking. Schools closed, and many workers were furloughed, laid off, or told to work from home, leaving many people confined to their homes (Evans et al., 2020). Unfortunately, these mitigation strategies critical to reducing the spread of COVID-19 have had a profound impact on families experiencing IPV, resulting in some people experiencing abuse being unable to leave a dangerous situation. Furthermore, the pandemic has exacerbated financial stress due to increased rates of unemployment, particularly for women (Kochhar, 2020). Economic strains on families contribute to interpersonal stressors, which may lead to violence (Choi et al., 2020); therefore, screening for IPV during the pandemic became even more important.

In the United States, COVID-19 mitigation strategies created barriers for pregnant people in their ability to access resources critical to their overall health (Choi et al., 2020). Shelters closed or reduced capacity, making safe housing alternatives difficult to find (Evans et al., 2020). This nebulous situation was made more challenging by a lack of safe and stable childcare and social supports (Evans et al., 2020).

In efforts to mitigate the risk of COVID-19 exposure to the community, many hospital units forbade visitors from entering. However, the labor and delivery unit has been the rare hospital area where a support person might accompany a birthing person. Once admitted, support persons are asked to refrain from leaving the labor room to reduce exposure and transmission of infection. Although staying committed to providing a safe experience during birth, health care providers found that privately screening for IPV became an

doi: 10.1016/j.nwh.2021.05.007

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unanticipated challenge. The usual one-to-one screening that occurred between a nurse and pregnant person was not an option. This prompted nursing staff to implement unique solutions in finding safe, private settings to screen for IPV.

Developing and Implementing an Infographic Poster

At a large, urban, tertiary health care setting, a multidisciplinary panel composed of the primary stakeholders of nurses, physicians, and social workers worked in conjunction with technology experts, interpreter services, and marketing personnel to create a simple process to screen for violence. A vibrant infographic with IPV screening questions and instructions on how to reach out for help was displayed in several languages in bathrooms throughout the perinatal service line (see Figures 1 and 2). The infographic contains questions about personal safety. Nurses were encouraged to, while orienting birthing persons to the labor room, subtly direct their attention to the infographic. The infographic uses health information technology (HIT) by including a Quick Response (QR) code that, when used with a smartphone or tablet, opens a text box that a person can complete by simply entering their name and date of birth. This type of self-administered screening has been proven as effective as discussions with a health care provider in disclosing health care issues (McNeely et al., 2015). The benefits to this mode of disclosure are that no verbal confirmation is necessary and no electronic trail is left on the birthing person's phone.

During the pandemic, the number of policy revisions for health care best practice was unprecedented. Goals were identified, barriers discussed, and interventions developed as the COVID-19 pandemic unfolded and mitigation strategies were put into place. Before the pandemic, intrapartum care providers were able to rely on their postpartum colleagues to complete the full safety assessment when needed. During the pandemic, the inability to separate a birthing person from their support person influenced the entire perinatal service line. A private screening assessment was no longer an option. The infographic became a quick alternative to the face-to-face assessment that was used by the perinatal team before the pandemic. Stakeholders aligned rapidly to develop and implement the infographic as they demonstrated a commitment to safety. An educational video trained health care members on how to use this new screening tool. Health care

FIGURE 1 **INFOGRAPHIC POSTER**

You Deserve to Feel Safe

Are you currently:

- Being **controlled** by someone close to you?
- Experiencing **unwanted or forced sex?**
- Being **isolated** from your family and/or friends?
- Having sexual contact where **force and/or threats** are used?
- Being **verbally insulted?**
- Being **hit, pushed, choked, restrained, or physically harmed** in any way?
- Being **threatened** by someone?

You are not alone. If you answer yes to any of these questions, we are here to help you in a confidential manner.

If you are feeling unsafe: Please scan the QR code and submit your last name and date of birth. You can also text (XXX) XXX-XXXX directly with your last nameand date of birth. For example: Smith, 09/17

A member of our department will reach out to you privately during your admission.

Si usted se siente inseguro(a): Por favor escanee el código de arriba y envié su apellido y fecha de nacimiento. Usted también puede enviar un mensaje de texto al (XXX) XXX-XXXX directamente con su nombre y fecha de nacimiento. Por ejemplo: Smith, 09/17

Un miembro de nuestro departamento se contactara con usted privadamente durante su ingreso.

若你覺得人身受到威脅，請掃描以上的二維數碼，並輸入你的姓氏和生日。
或者你也可以直接將你的姓氏和生日傳短訊至 (XXX) XXX-XXXX。
例如：Chen (陳) 09/17

我們的工作人員會在你的住院期間私下與你聯繫。

若你觉得人身受到威胁，请扫描以上的二维数码，并输入你的姓氏和生日。
或者你也可以直接将你的姓氏和生日传短讯至 (XXX) XXX-XXXX。
例如：Chen （ 陈 ）09/17

我们的工作人员会在你的住院期间私下与你联系。

Se nao se sentir seguro: Por favor, leia o código acima e envie o seu sobrenome e data de nascimento. Voce Também pode enviar uma mensagem de texto para (XXX) XXX-XXXX diretamente com o seu apelido e data de nascimento. Por exemplo: Smith, 09/17

Um membro do nosso departamento entrará em contacto con voce em particular durante a sua admissão.

QR Code

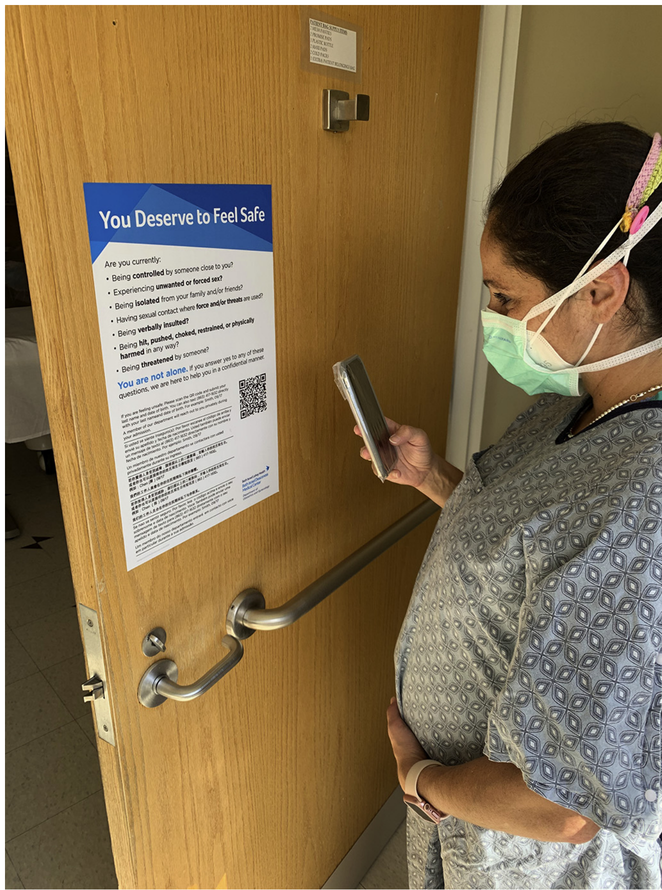
Beth Israel Lahey Health
Beth Israel Deaconess Medical Center
Obstetrics and Gynecology

Note. QR = Quick Response. Copyright 2020 by Beth Israel Deaconess Medical Center. Used with permission.

providers familiar with screening methods, policies, and community resources can promote the early prevention and reduction of IPV (Deshpande & Lewis-O'Connor, 2013).

The IPV screening infographic includes questions such as *Are you currently being controlled by someone close to you?*, *Are you currently being isolated from friends and family?*, and *Are you currently experiencing unwanted or forced sex?* When a person responds "yes" to any question on the poster and uses the QR code or text box to reply, an alert e-mail is sent automatically to nurse leaders. The leader promptly communicates with the primary care team to develop a separation strategy to secure a private setting for a conversation to occur with the birthing person. This may include asking the support person to step out for any number of reasons. An individualized discrete follow-up plan of care is then developed between the birthing person and their health care team to address their acute safety needs and safety planning for their future. A face-to-face,

FIGURE 2 **THE POSTER DISPLAYED IN A BATHROOM**



meaningful, therapeutic conversation to further address concerns can result in more open disclosing of episodes of abuse (Deshpande & Lewis-O'Connor, 2013).

The average number of annual births at our institution is 5,300, or 430 per month. Before the pandemic, the occurrence birthing persons who were experiencing IPV and disclosed this for the first time during their intrapartum admission happened, on average, two times per month. Based on reports suggesting increased rates of violence during the pandemic, we were prepared to expect slightly greater endorsements to these screening questions. Our data have remained the same throughout the pandemic, with an average of two new disclosures per month. However, it is impossible to ascertain how many individuals would not report such violence if not afforded privacy, especially from the purported perpetrator. Obviously, if a person is involved in a violent relationship, the need to acknowledge the trauma and then develop a plan for safety is paramount.

Implications for Practice

Empathic, compassionate communication is necessary to address the needs of vulnerable individuals, making a

> Stakeholders aligned rapidly to develop and implement the infographic as they demonstrated a commitment to safety

thoughtful approach to IPV screening essential. Health care providers have the knowledge and experience to play an integral role in helping individuals be empowered to engage in their health care. The goal of such intervention is to increase a person's sense of control and independence (Andresen, Bermele, & Urbanski, 2018). The objective is to have health care providers lead with empathy and stay updated with community-specific resources to better serve people who are experiencing violence. Integrating HIT, such as with the implementation of this infographic poster, enables individuals to have active participation in their health care and may contribute to improved health outcomes (Bianchi et al., 2016; Dalal et al., 2016; Patmon et al., 2016). Institutions should enhance HIT systems to engage people while ensuring equitable access. Frequent use of technology, such as QR codes, increases access to self-administered screenings and health care information. After the implementation in IPV screening at our hospital, QR codes have been used in the perinatal service line to provide breastfeeding education and information on community resources, such as safe housing options.

IPV remains a major source of morbidity and mortality, with women experiencing a lifetime prevalence rate of 22% (Alhusen et al., 2015). Research on IPV during times of public health crisis suggests that the severity of abuse may increase (Stanley, 2020). Additionally, during this time of quarantine, a 20% rise in IPV throughout the world has been estimated (Evans et al., 2020). The IPV assessment screening infographic poster may be used not only during the COVID-19 pandemic but in a variety of clinical settings where a struggle to safely assess for violence is identified. Evidence indicates that the act of screening for IPV may serve as an intervention itself, bringing the needed attention to the root cause of physical and mental health problems reported by individuals who experience IPV (Bianchi et al., 2016).

Potential barriers to screening for IPV in the health care setting include lack of time, lack of a private location for discussions, and lack of consistent education and policies (Bianchi et al., 2016). The infographic poster described here addresses some of these concerns because it is a short list of questions displayed in the privacy of a bathroom that a birthing person can complete independently. Limitations of the use of the infographic poster include the comfort level of those providing answers, a lack of full understanding of the impact of answering yes to the questions, individuals' level of literacy, and fear of the perpetrator's knowledge of their use of the infographic. These limitations are important considerations for

 doi: 10.1016/j.nwh.2021.05.007

development of best practice for intrapartum care. Health care providers should continue to find opportunities for birthing people to collaboratively engage in developing their plan of care while also acknowledging the effects of COVID-19 on their birth experiences (Choi et al., 2020).

Conclusion

The COVID-19 pandemic has made it necessary to find innovative strategies to facilitate safe assessment and intervention for IPV. In the project described here, multidisciplinary stakeholders shared their expertise to develop protocols for improved pathways for early IPV assessment. Positive responses were received from health care providers and birthing persons with regard to the infographic. Health care providers reported a relief in knowing that they were equipping people with this support. Birthing persons reported that they were glad to see the hospital was creating a safe and private way to ask for help, with one saying, “Just seeing this infographic identifies that this institution is concerned for my safety.” This creative process for IPV screening has helped meet birthing persons’ acute care needs during COVID-19 and may have long-term benefits after the pandemic is resolved in a variety of hospital units. Facilitating the use of HIT to engage individuals in their health care may improve health outcomes. The pandemic has highlighted how much work needs to be done to ensure that people who experience IPV continue to obtain access to support and health care (Evans et al., 2020).

Author Disclosures

The author reports no conflicts of interest or relevant financial relationships.

Funding

None. **NWH**

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