Celebrating Solutions Award
Nomination Form

Legal name of organization: Planned Parenthood of New York City, Inc.

Year established: 1916

Program nominated for award (if different):
Intimate Partner Violence Screening in Reproductive Health Centers

Year established: 2003

Address: 26 Bleecker Street

City/State/ZIP code: New York, NY 10012

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Brief description of organization: Founded in 1916, Planned Parenthood of New York City's (PPNYC) mission is to empower individuals to make independent, informed decisions about their sexual and reproductive lives through the provision of information and health care, and the promotion of public policies that make these services available to all.

Geographical area served: New York City

Is the organization tax-exempt under IRS 501 (c) (3) guidelines or a public agency/unit of government? Yes.

Please check up to five descriptors that best apply to the program you are nominating:

- Shelter-based
- X Counseling
- X Health care setting
- X Dating violence
- X Underserved population
- _ School/youth violence
- _ Faith-based
- _ Elder abuse
- _ Legal aid/assistance
- _ University setting
- _ Batterer treatment
- _ Prison-based
- _ Stalking
- X Coalition/collaboration
- _ Transitional housing
- _ Technology/Internet service
- _ Employment/training program
- _ Victim relocation
- _ Hotline service
- _ Public awareness/education
- _ Other ____________________
As one of the goals of the Mary Byron Project is to disseminate information about cutting-edge programs and best practices, we wish to post exemplary Celebrating Solutions Award nominations on our website (www.marybyronproject.org). Those posted will include the organization's website address, telephone number, and e-mail address. If you have concerns about this request, please address them to information@marybyronproject.org, prior to submitting a nomination.

By my signature on this letter, I grant the Mary Byron Project permission to use the contents of my nomination for the Celebrating Solutions Award in the manner and for the purposes set above. I further affirm that I am fully authorized to grant such permission to the Mary Byron Project.

Signature  

Date: November 18, 2010
1. Describe the mission of your organization

Founded in 1916, Planned Parenthood of New York City's (PPNYC) mission is to empower individuals to make independent, informed decisions about their sexual and reproductive lives through the provision of information and health care, and the promotion of public policies that make these services available to all. The agency provides comprehensive and affordable reproductive health care services to approximately 47,000 clients annually through our three health centers in the Bronx, Brooklyn, and Manhattan. PPNYC's clients reflect the socioeconomic diversity of New York City as a whole. Among our clients receiving clinical services, approximately 30% are Black, 25% are Latino, 20% are White, and 3% are Asian (the remainder self-identify as "other"). The vast majority of clients served are female, and more than half of all clients are low-income, with approximately 67% of clients covered by Medicaid, other types of public insurance, or eligible for the PPNYC sliding scale fee.

2. Describe the most innovative aspects of the program

For more than two decades, the Surgeons General and major medical associations have developed policy statements and practice recommendations supporting IPV screening across medical settings. In particular, IPV screening and response protocols have been recommended for all reproductive health clinics, as sexual and reproductive health (SRH) care providers serve women during the highest risk years for IPV and femicide. Nonetheless, screening procedures, responses, and provider attitudes about screening for IPV have varied widely, and most research has focused on evaluating screening methods and provider attitudes in emergency room and primary health care settings, rather than in reproductive health care settings.

In 1998 when revisions were being made to its medical history forms, PPNYC recognized the importance of incorporating brief standardized screening questions to identify clients who had experienced sexual and physical assaults by intimate partners. A traditional, three question screening tool that had been used in other medical settings was implemented, but based on internal audits, we found that IPV disclosure rates were too low based on known rates in New York City. To make improvements, in 2003 we collaborated with Columbia University to develop a novel screening tool, which we believed would increase disclosure rates. With this change came the development of specialized programming for relationship violence screening, assessment, counseling, and referral services in all PPNYC health centers. The program takes a comprehensive approach that includes universal screening with new, standardized questions; specialized training for health care staff about responding to disclosures of IPV; and additional follow-up with a health center social worker for further assessment, safety planning, and referrals to local IPV organizations and hotline numbers. We believe the most innovative aspects of our program include:

- This is an evidence-based program from design to implementation to evaluation of its efficacy. The program also allows for research on the association between IPV and SRH concerns. For example, we have found an association between IPV and abortion number and timing and sexually transmitted infections (STIs).
- IPV screening includes physical, emotional, and sexual aspects of violence, and if it occurred in the past year or ever in their lives, which is a wider range and longer time frame than other standardized, short screens used in medical settings. Staff are also trained to recognize and respond to teen dating violence as well as in domiciled relationships.
- Health care staff respond to IPV disclosures with focused assessment and counseling of SRH care needs to reduce risks associated with birth control sabotage, sexual injury, and STIs/HIV. Further, the program includes social workers in the health centers who can provide greater depth of assessment, safety planning, and referral to IPV agencies.
- Based in one of the largest family planning and abortion services organizations, our ability to reach a wide number and demographic range of women makes this unique IPV screening and response program.
- We also collaborate with community IPV agencies, which includes referral, cross-training of providers on the relationship between IPV and SRH, and the need for bridging women between service providers for comprehensive social, legal, and health services.

3. Program implementation. What barriers did your organization have to overcome? How did you marshal the necessary resources for implementation?
Throughout the development, inception, and continuance of the program, we have researched provider attitudes and barriers, and have therefore been able to continuously monitor and respond to necessary resources and barriers. Further, we considered client barriers to disclosure in a health care setting. There is a continual process of review and service improvement.

Before the program began, SRH providers were overwhelmingly supportive of the need for screening, but more than half were concerned about how to incorporate the screening into an already busy health center schedule. It was, therefore, critical for the project to develop a new screening tool that would enhance clinical practice and not deter from other tasks and activities of the health care setting. With this in mind, a committee of health care professionals collaborated with the researchers to develop the new screening tool and response protocol. Specialized IPV training was also provided on basic aspects of IPV processes and outcomes for women, and about the use of standardized screening questions that had been shown to increase the frequency of provider-client discussions about IPV in OB/GYN settings. Later, an additional training was conducted with the Family Violence Prevention Fund about reproductive control and related risk reduction counseling techniques for birth control options, STI testing, and overall sexual health.

We have conducted research to evaluate provider attitudes and barriers to the program. The study included all staff involved in the program, including social workers, advanced practice clinicians, and health care associates. The majority of health care providers supported IPV screening, but said the following barriers made it more difficult to screen for IPV:

- Not enough time to conduct screening in addition to other health care needs.
- Limited availability of written referral and educational resources to give to clients.
- Lack of training on how to respond to IPV disclosures and the association between IPV and reproductive health outcomes.

In disclosing IPV, clients may also experience:

- Fears about how the information in a medical chart will be used or who will find out about their IPV disclosure or their health services.
- Paperwork fatigue and length of the health care visit may prevent clients from disclosing IPV to shorten the number of questions they have to answer and the length of the appointment.
- Lack of understanding of IPV and its connection to SRH prevents clients from understanding why they are being asked screening questions and how disclosure might be helpful.

To assess bridging women between services, a community forum was organized in October 2009 with health care providers and IPV experts who related several barriers between SRH and IPV services, and suggestions were made for better collaboration:

**Barriers**
- Fear of the unknown: providers do not know each other across agencies, and do not know what to tell their clients to expect from a referral.
- Concerns that client language barriers will not be adequately managed, and what translation services exist across agencies.
- Lack of funding for agencies to provide their own specialized services and having staff time to facilitate client movement to other services.
- Trust among providers from different agencies that have training on IPV and will treat clients sensitively and competently.
- Community IPV specialists do not know all the potential impacts of IPV on reproductive health or how to provide health-related safety planning.

**Recommendations**
- Bring mobile health care vans, visiting nurses, and “promotoras” or health care liaisons to IPV agencies to facilitate SRH care.
- Expand youth friendly services for teen dating violence and health care.
- Expand educational outreach and services to specific immigrant communities, and gain specialized expertise in serving immigrants and handling language and cultural barriers.
- Cross-training of professional staff in the areas of IPV and reproductive health to promote networking and education about best practices. “The two worlds have a lot to learn from each other” – Advisory group participant.

**4. How do you know your program works?**
In 2003, the Centers for Disease Control funded researchers from PPNYC and Columbia University to develop an IPV screening approach to identification, management, and referral within health care settings that would be acceptable to younger women, who had not been the focus in previous publications about screening. It included the development and testing of a comprehensive IPV screening tool that included current and past physical, emotional, and sexual violence. The definition of IPV we used to guide this project was as follows: a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. We looked at these behaviors as perpetrated by someone involved in an intimate relationship where the actions were aimed at establishing control by one partner over another. The project had two phases:

In Phase I, we conducted an anonymous survey to investigate the attitudes and expectations of young women toward screening by health care providers. Of the 645 ethnically diverse women aged 15 to 24 who were family planning patients, 45% reported having EVER been abused by a
partner (physical, sexual, or emotional). Of those who had been abused, 55% reported that they had been asked by a provider, but only 20% had disclosed the information when asked. 98% of women responded positively to being screened, saying that they would not mind answering screening questions in the health care setting. Among the choices for whom they would want to talk to about IPV more women reported that they wanted to speak with a health care provider (95%) compared to their mother (90%) or a counselor (89%). In addition, women reported discomfort with the word “abuse” and said that they preferred responding to descriptions of behaviors rather than labels. Based on the results of Phase I, we developed training for providers and provisional screening tools that were piloted in the same health center six months later.

In Phase II we piloted screening questions that were added to the standard medical history form completed by all health center clients. We randomly assigned 799 women, ages 15 to 24 years, to complete one of the three tools for violence screening. We also assessed provider feasibility and acceptability across the three screening approaches. Based on the findings, a new screening tool and response program was created and incorporated into health care services without interrupting the patient flow.5

After the new screening tool and response protocol were in place for one year, the Robert Wood Johnson Foundation funded a study to compare IPV disclosure rates of women who had completed an older, traditional medical screening tool (n=420) to those who completed the new PPNYC screening questions (n=385). Women completing the new screening form were more than 2.5 times more likely to report past and current violence (mutually exclusive) and over 4 times more likely to report experiencing both past and current violence compared to women who completed the older, traditional screening questions.5

To further evaluate the program components, we conducted five focus groups with 75 PPNYC health care providers, of whom 65 (87%) also completed written surveys about barriers to screening in family planning health centers.7 Providers included certified nurse-midwives, nurse practitioners, physician assistants, social workers, and health care associates. Barriers included lack of time, training, and referral resources. Attitudes toward screening were positive overall, but a number of providers expressed frustration with clients’ lack of follow-up to recommended referrals, were concerned about taking too much time away from other health care matters, and believed that certain job roles were more appropriate for conducting screening than others. Providers also expressed a desire for more training about the connection between IPV and reproductive health as well as for responding to disclosures of violence. Program evaluation is an ongoing process, and we plan to continue to assess aspects of the program into the future, especially specialized SRH counseling for IPV and associations between IPV and SRH outcomes.

5. Who are your key partners? What are their roles?
PPNYC has made efforts to increase coordinated community responses between health care professionals and IPV specialists. For example, we convened an initial discussion group of 12 interdisciplinary providers from across New York City, which included professionals from the NYC Department of Health and Mental Hygiene, health centers and hospitals, the NYC Administration for Children’s services, and five different private domestic violence agencies. Screening for IPV is only as helpful as the response that follows. Increased cross-training is needed about the specific connections between physical and sexual violence, reproductive
coercion, and reproductive health, including relationship dynamics that inhibit the use of condoms, interfere with birth control methods and lead to unwanted pregnancy, monitor or restrict access to health care, and impact pregnancy continuation and termination. To strengthen the connection between SRH and IPV-related service providers, PPNYC recently applied for a small grant from the HHS Office of Women’s Health to: coordinate and conduct a two-hour session between PPNYC’s Social Workers and staff from five IPV service organizations to identify issues regarding linkages between IPV and SRH services, and develop a seamless referral system; develop a curriculum; provide a half-day training workshop on reproductive control and IPV for 35 NYC-based providers; and, produce a comprehensive referral guide of both IPV and SRH organizations to increase knowledge about the availability of services.

6. Could/should your program be replicated in other areas of the country?
In the last 10 years, national research on IPV and reproductive health has expanded in both breadth and depth from studying the association among IPV and reproductive health outcomes to identifying mechanisms of influence and empirically based screening practices. Evidence for mechanisms of influence, including birth control sabotage, pregnancy manipulation, health care monitoring, and partner refusal to use a condom support an expanding role for reproductive health professionals.  

We believe that universal IPV screening and response protocols should be implemented in all reproductive health care settings using standardized, empirically tested screening instruments and response protocols such as those being used and tested by PPNYC. While significant strides have been made in understanding how IPV affects SRH, providers need to be aware that this is a prevalent health care issue that requires universal screening and appropriate follow-up assessment and referral. This includes improvements in youth-friendly services for teen dating violence and health care, and expanded education and outreach services to immigrant communities with specialized expertise in language and cultural barriers.

PPNYC’s IPV practices and research have already impacted the policy and practice recommendations of the umbrella organization, Planned Parenthood Federation of America, which has subsequently developed an IPV training encouraging screening by all of its affiliates. Our program should be implemented by other family planning, abortion, and OB/GYN providers outside of the Planned Parenthood network. Although social work services are not routinely available in SRH settings, as they are at PPNYC, health care providers should network closely with their local IPV agencies to bridge women between services. We also believe that IPV agencies should incorporate specific SRH safety planning that includes health care utilization.

7. Agency workplace policy that addresses domestic violence
PPNYC addresses domestic violence on several levels. All employees are required to complete a human resources training on workplace violence, which includes an IPV component. A policy exists for universal IPV screening of all health center clients, as well as a protocol for handling dating violence disclosures among adolescents in our educational programs. As Planned Parenthood offices around the country are targets for protest and violence by people who wish to restrict women’s health care options, the potential for any form of workplace violence, whether it be IPV or other gender-based violence, is constantly monitored by a security system that includes security guards, metal detectors, secured swipe card entrances to inner offices, and a
reporting protocol for any form of threat to an employee. PPNYC’s Human Resources department is prepared to assist any staff addressing IPV, by alerting our security guards to potential threats, escorting staff to their cars or public transportation, and coordinating direct referrals for shelters or counseling through an employee assistance program, which provides confidential assistance from professional clinicians and counselors for a variety of personal concerns.

8. Has the agency and/or nominated program received VAWA funding?
No, PPNYC has not received VAWA funding.

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1) Submit three letters of support which illustrate why the applicant or nominee is deserving of the award. All letters should include an address, email address and telephone number for confirmation. One letter *each *should be submitted by:

A partnering or collaborative organization or agency; *and *
1. See letter attached from Futures Without Violence.

A victim’s organization.
2. See letter attached from Sanctuary for Families.

An elected official who represents the city, county, or state where the program operates; *or* *

2) Submit proof of 501 (c) (3) status if the program is operated by a non-profit, non-governmental agency.
See 501(c)(3) letter attached.

3) Submit last year’s budget for the program to be served by the award.*
Screening and response to partner violence is considered part of comprehensive sexual and reproductive health care at PPNYC. We are not specially funded to provide this service as separate and distinct from our other health care services (such as family planning counseling, gynecological exams, colposcopy, or abortion). It is not a reimbursable service via Medicaid, other public entitlement programs, or via private insurance.

PPNYC’s provision of intimate partner violence (IPV) screening and response is supported through the agency’s overall clinical services operating budget, and there is no budget specific to the program. Budgets have been developed for unique projects related to IPV, with periodic funding for such work provided by interested foundations or donors. For example, the CDC and the Robert Wood Johnson Foundation have funded separate research projects to create, test, and improve the program. Futures Without Violence (formerly the Family Violence Prevention Fund) has conducted pro-bono training for PPNYC staff, and the Society for Family Planning is currently funding a new study of the association between IPV and unplanned pregnancy. Any additional financial support that can help us maintain and improve the program is therefore essential to its continued growth, and we regularly seek such support from private sources.

4) Respond to the following questions:

a) What is the approximate number of individuals served annually by the applicant or nominee?
PPNYC screens all health service clients for partner violence (i.e., universal screening) as part of the medical history assessment, which equals about 50,000 clients (95% of whom are women) per year across three health centers in the Bronx, Manhattan, and Brooklyn (with a fourth,
smaller center due to open on Staten Island in early fall). About 20% of our clients report partner violence during the medical history and assessment, and are offered information about community services for IPV, counseling about reproductive health needs and risks related, and a follow-up meeting with a PPNYC social worker at the time of their visit (i.e., they do not have to come back another day to see a social worker).

b) How many paid staff and volunteers are used to administer the nominated program?
Women are screened by advanced practice clinicians (APCs) and family planning counselors, which include 50 staff across our centers. If violence is reported, PPNYC employs three full-time and one part-time licensed social workers who are trained to respond with a risk assessment and follow-up counseling and referral. We consider IPV screening as part of comprehensive reproductive health services, therefore health center staff receive training on relationship violence dynamics, effects, and intervention. We expect that a disclosure of relationship violence at any point during a health visit will be responded to as outlined in PPNYC policies and procedures (see attached). Additionally, social work services are not available at most other reproductive health centers, which makes our IPV services unique, but also more costly, as social work visits are not reimbursed.

c) Are there past awards, accolades, and grants furnished upon the applicant or nominee that would further exemplify its success in combating domestic violence?
We have not received awards other than peer reviewed acceptances of conference presentations and journal publications of our domestic violence work. However, related to our commitment to quality services to youth, which includes IPV screening of approximately 6,400 adolescents each year, we received a 2011 certificate of recognition from the NYC Department of Health and Mental Hygiene for “Best practices in adolescent sexual and reproductive health services.” PPNYC was recognized from among multiple NYC-based providers.

d) If funding were not an issue, what (if any) changes or additions would you make to your program in the future? What are the long term goals for your program? We are interested in hearing both your practical goals in addition to any lofty dreams you might have for the future.

Our practical goals for the coming year are to provide on-going staff training, with a special focus on new reproductive control research published this past year; planning with local domestic violence service providers for smoother coordinated services; and improving counseling protocols for reproductive health needs related to partner control. A loftier goal, in terms of both time and cost, would be to conduct a rigorously designed outcome study of women who disclose partner violence and the impact of the services they receive at PPNYC.
In addition to the questions and requirements listed in your letter, your responses to the questions below will help the final review committee to better understand the value of your program and services. Your answers to these questions should be as brief and focused as you think is needed. Any requested supplemental resources should be attached.

1. Please provide a copy of your screening tool. Are there versions of the screening tool in Spanish or any other languages?  
The screening tool is available in both English and Spanish (see attached). The tool was last updated in July 2011, with two new questions related to reproductive control. We do not have the tool available in languages other than English and Spanish, but staff are trained in language access practices via a phone translation service, as well as certified health care translators in person for Spanish speakers. The screening tool is part of our standard medical history form because we want clients to perceive the questions as part of a holistic reproductive health care approach.

2. Please provide more information on your curriculum; how do you train staff to recognize IPV? Is there a standardized training program in place?  
In the three PPNYC health centers, all advanced practice clinicians, family planning counselors, and social workers are expected to play a role in assessing if clients are experiencing relationship violence and ensure follow-up and referral services are offered during their health care visit. These staff receive annual refresher training on PPNYC policies and procedures for partner violence screening and follow-up (policies and procedures are attached). After a client answers the screening questions on the medical history form, a health care staff reviews their answers with them, which includes a secondary verbal screen for partner violence, if it was not reported on the form. If a woman reports current or past violence, they are counseled on risks to their reproductive health, options for contraception methods, and more frequent health care screening that may be best for them in their current relationship. This involves a focus on reproductive coercion as well as overall injury, safety, and other community services. Staff are trained to ask about emotional, financial, physical, and sexual abuse, as well as sexual and reproductive coercion and control. Every client who discloses partner violence is then offered an additional meeting with an on-site social worker, which adults may accept or decline (youth must meet with a social worker after reporting partner violence). If they choose to meet with a social worker, a more full risk assessment, crisis intervention, and/or counseling and referral is provided as necessary.

In addition to annual training on policies and procedures for partner violence screening, additional topics are added such as new research on reproductive control and best practices for abortion and contraception services for women experiencing partner control. These topics are sometimes presented by guest speakers or experts from local or national organizations.
3. Have you implemented (or do you plan to implement) the 2009 focus group recommendations, specifically:

a) Creating mobile health care service teams
Unfortunately, there is currently no funding available for this, however, our development staff regularly investigate grant opportunities, including those for mobile medical service delivery.

b) Expanding youth friendly services
PPNYC operates a Training Institute through its Education & Training department, providing two-dozen trainings to youth-serving professionals annually. On July 21, 2011, staff conducted a training titled, “Healthy Relationships: Helping Teens Form Relationships That Add to Their Well-Being.” Youth-serving professionals are in a unique position to help young people explore what they need to consider at each stage of an intimate relationship. The goal of the training was to prepare attendees to: articulate what constitutes a healthy relationship; describe techniques to raise youth’s awareness of the characteristics of both a healthy relationship and an abusive relationship; and identify community resources that can support youth in dealing with an unhealthy relationship.

We also offer monthly Center Teen Nights in all of our health centers, which bring groups of teens into the center during special hours, where they receive educational and optional family planning services. These nights provide a “teen friendly” and accessible introduction to SRH services.

c) Expanding “educational outreach and services to specific immigrant communities,” including services for immigrants who may face language/cultural barriers? How have you done this?
PPNYC has several new program initiatives in progress that are specific to immigrant communities.

Recognizing that Latina immigrants face numerous obstacles to accessing reproductive health services, such as unfamiliarity with the health care system, lack of health insurance, as well as cultural and linguistic barriers, PPNYC is addressing such challenges through the Promotora de Salud (PdS) program. PdS are peer advocates and educators who bridge the gap between their respective communities and the health care system.

PPNYC’s PdS will help community members learn about and utilize our health centers or other reproductive health care centers in New York City, offer culturally relevant sexual and reproductive health education, and act as advocates in assisting peers to obtain health care services. To help us build a strong PdS program that is aligned with community needs, we have conducted two qualitative focus groups with women at immigrant-serving CBOs in the Bronx. We will begin recruiting PdS candidates during the late summer and fall; selected candidates will participate in a nine-session training program. The program is supported by New York State Department of Health Family Planning funds through 2015.
Researchers from the State University of New York and Family Planning Advocates of New York State are working with PPNYC on a language access initiative that began in 2010: Understanding and Improving Family Planning Services through Language Assistance. It is a state-wide intervention study to document and improve language access services in reproductive health centers. During the assessment phase of this project, PPNYC was determined to have the most advanced language access training and procedures of among 10 other state-wide health centers. We are currently in the intervention phase, where we are improving our internal ability to document and monitor which languages we provide translation for and whether there are ethnic communities that are underserved.

4. What are your policies for transferring women to support once screening has uncovered evidence of domestic abuse? Expand upon your relationship with local shelters and legal service providers.

The vast majority of clients who report partner violence receive SRH counseling and information related to their relationship-specific needs, and refuse further social work services at PPNYC or elsewhere. We feel these disclosures primarily present us with an opportunity to provide information and harm reduction through contraceptive options that the woman is most able to control in her specific relationship, and STI screening and treatment. We do however try to bridge women to domestic violence agencies in New York City as much as is requested by our clients. We provide crisis intervention, and assist with client calls to hotlines and service agencies. We have been, and continue to, work on developing closer collaborative relationships with DV service providers that will enhance smooth coordinated responses to partner violence between health care and social service providers. For example, the past month included a cross-training meeting between Day One, a teen dating violence organization, and PPNYC clinical staff, which included discussions of smooth transition of youth between health care, legal and social services. Also in the past week, we had an administrators’ meeting with one of the largest DV organization in New York state – Sanctuary for Families – about both clinical and policy initiatives that we can collaborate on in the future.

5. Have you found that, as a result of more effective screening, more women are accessing protection from abuse? Has there been any increase in the number of women receiving counseling or other forms of support? Have you researched – or do you plan to research – real-world effects on enrollment in support services and, ultimately, overall health?

PPNYC is committed to recognizing and addressing partner violence to improve the lives of the women we serve. As a reproductive health organization, our ability to provide direct protection from an abuser’s behavior is limited in scope. However, our research study of improved screening questions showed that we have increased the number of women disclosing partner violence from 11% in 2006 when an older screening tool was used to 24% after 2007 when we implemented improved screening and follow-up procedures. By improving our screening and response program, we are able to provide more individualized reproductive health counseling that we believe will decrease risks associated with partner violence such as birth control.
sabotage, sexual coercion and control, unintended pregnancy, and abortion. This is our primary objective, but we also try to bridge women to additional partner violence services.

For abortion services in particular, when partner coercion is sometimes a factor in the decision to terminate a pregnancy, partners are not allowed to accompany patients into the procedure areas nor are they allowed to be present at the initial counseling assessment. Partners may be present during later counseling sessions to support clients, but only after a separate interview with the client. This is not always standard procedure by other abortion providers, but can be critically important for a woman experiencing reproductive control through forced choice of or unwanted pregnancy or termination. Further, it also happens that a woman chooses to terminate a pregnancy in a way that ensures her safety in her relationship, where a partner may not be present during the visit. Social work staff are trained to provide information about a variety of options for termination, such as both medication and surgical procedures, which may provide different safety needs for each individual situation.

There are no studies to date of efficacious counseling or response protocols for reproductive health and partner violence, therefore we do not have data about program impact beyond the efficacy of the screening tool in the SRH care setting. This is, however, part of future directions.

6. Please provide an example of a client who benefited from having the screening and referral for services.

We are providing an actual social work case note of an adult client in the past year, without any identifying information, to serve as an example. This client would have been screened by a health care worker prior to an abortion procedure, without her partner present, and subsequently referred to see the social worker in the health center. The following description is at the follow-up to screening.

Patient in clinic for elective termination of pregnancy. Patient disclosed during abortion counseling session that she did not want to have an abortion and was being forced by her partner to terminate the pregnancy. The Patient was escorted by her partner to the clinic and was waiting in the escort waiting area. Patient stated that she had no place to stay other than with her mother, which was not safe because her partner knew her mother’s address. Patient stated that over the course of their three year relationship her partner has often been verbally and emotionally abusive and at times physically violent. Patient stated that she was forced once before to terminate a previous pregnancy. Patient denied having reported the abuse during the previous abortion because she thought “no one would help her because she stays with him.” Patient stated that she has tried several times to leave the relationship, but when she attempts her partner apologizes for the abuse and vows to change and tells Patient that they should start a family together. Patient states that she then becomes pregnant and her partner forces her to have an abortion. Patient states that she has called [a domestic violence agency in New York City] for shelter but has had difficulty being placed because she is not entering with a child.

Patient was informed that we would be able to assist her in contacting [name of shelter] and would be able to get her out of the clinic safely without her partner’s knowledge by taking her out the back entrance. The Patient was then assisted in contacting the shelter. Shelter operator
spent over an hour with Patient and Social Worker on the phone trying to secure a bed in a DV shelter for the Patient. Several DV shelters were called and had family availability, but none for a single woman. Shelter operator suggested contacting a convent called the Missionaries of Charity that provide food and shelter for pregnant women. Social Worker contacted the convent and was given information on shelter regulations but was asked to call back and speak to the Mother Superior after prayer worship to secure a bed for the Patient. Social Worker also contacted DV shelters in Long Island at the suggestion of [shelter name], which does not have access to DV shelters outside of New York City. Both Long Island DV shelters were 2 hours away from the city and would be an expensive commute for the Patient, who needs to travel into the city.

The Patient was then counseled on the remaining options: to either wait to contact the convent and check availability, or apply for entry into the New York City shelter system that day, and contact [shelter name] again the following day for possible availability.

We end the case note here to protect other information about the client, but her ability to consider all her options for shelter as well as proceeding with the abortion, allowed her to make the decision that was best for her at the time. She was able to spend the whole day at the center in order to come to a resolution, assess risk, and create a safety plan. As PPNYC is a target of anti-choice extremists, we have high levels of security at all our health centers, which also increases safety from partner violence in and around our clinic site. We are able to access immediate police response as needed, for any safety reason, and all staff are trained on safety procedures for strangers as well as those accompanying women to appointments.

7. We were unable to locate any reference to the IPV screening on your website. Is there a reason it is not referenced?

Published journal articles about our program have been listed on PPNYC’s website since 2010 via the following link: http://www.plannedparenthood.org/nyc/publications-15145.htm

Links to articles are mid-way down the page under “Reports and Research.”

PPNYC has been conducting IPV screening and referral in its health centers since 2003. For a number of years, we have included healthy relationships among campaign themes and in our literature, and we will soon be publicizing this service on our website more formally.

Our parent organization, Planned Parenthood Federation of America (PPFA), is currently revising and training for new screening procedures for all Planned Parenthood affiliates, based in part by the early efforts that PPNYC developed in our centers. Part of the new PPFA policy for all affiliates includes provision of educational messaging via posters in our client waiting areas and on our website. These will be provided by Futures Without Violence from its campaign. “Did you know your relationship affects your health.” We expect partner violence messaging will be posted on our website in the fall 2011.
July 29, 2011

Celebrating Solutions Awards
Mary Byron Project, Inc.
10401 Linn Station Road, Suite 116
Louisville, KY 40223

Dear Mary Byron Project Celebrating Solutions Awards Committee:

On behalf of Futures Without Violence, formerly the Family Violence Prevention Fund, I am pleased to provide this letter of support to nominate Planned Parenthood of New York City's (PPNYC's) Intimate Partner Violence Screening in Reproductive Health Centers Program for a Mary Byron Project Celebrating Solutions Award. As a partnering agency, Futures Without Violence has been working with PPNYC for a number of years to acknowledge and help find ways to alleviate the impact of partner violence on women's health.

PPNYC provides a comprehensive array of sexual and reproductive health services, and recognizes the connection between women's health and violence. In 1998, PPNYC began integrating partner violence screening into its clinical services protocol, and developed specialized programming in 2003. Since this time, PPNYC has been able to test and modify screening questions, and has implemented an intimate partner violence screening program.

Futures Without Violence has also been working tirelessly to promote and test new partner violence screening questions and follow-up procedures for use in women’s health care settings. While we have been conducting research with partners in California, we have had an ongoing collaboration with PPNYC about their screening research and practices. This has included efforts toward the creation and implementation of partner violence screening standards by Planned Parenthood Federation of America (PPFA) for their 83 nation-wide affiliate organizations operating 800 health care centers. PPNYC was one of the first affiliates of PPFA to create, test, and implement screening practices within their three health centers. PPNYC presented their work at our biennial conference and at a special strategic meeting held in Washington, D.C. during the spring 2011 with practitioners and policy and research experts on the intersection of reproductive health and violence. They have also organized training sessions with us for their health care staff to improve screening and response.

I strongly support PPNYC's Intimate Partner Violence Screening in Reproductive Health Centers Program, and look forward to continuing to collaborate with PPNYC in the future. If you have any questions regarding our work with PPNYC, please contact me at the phone number or email address listed below. Thank you for your consideration of this important nomination.

With best regards,

Rebecca Levenson
Senior Policy Analyst
100 Montgomery Street, The Presidio
San Francisco, CA 94129
Email: rlevenson@futureswithoutviolence.org
Telephone Number: (415) 678-5500
August 2, 2011

Celebrating Solutions Awards
Mary Byron Project, Inc.
10401 Linn Station Road, Suite 116
Louisville, KY 40223

Dear Members of the Awards Committee:

Sanctuary for Families is pleased to support the nomination of Planned Parenthood of New York City's (PPNYC's) Intimate Partner Violence Screening in Reproductive Health Centers Program for a Mary Byron Project Celebrating Solutions Award.

Sanctuary for Families provides domestic violence victims, sex trafficking victims, and their children with a range of comprehensive services, including shelter, counseling, legal services, and economic empowerment initiatives. We also provide outreach, education, and advocacy. Annually, Sanctuary for Families reaches more than 11,000 victims and their children through direct services. In addition, our education and awareness-building initiatives connect with more than 20,000 community members each year, including local leaders, social service and legal professionals, law enforcement officials, and health care organizations such as PPNYC.

PPNYC provides a full range of sexual and reproductive health services to more than 49,000 clients annually at its three health centers in New York City. Recognizing the link between women's health and violence, PPNYC implements evidence-based screening and follow-up services for intimate partner violence as a part of routine reproductive health visits. PPNYC and Sanctuary for Families have consulted with each other on the many ways in which we could work more closely together, including discussions of coordinated community responses to violence in the lives of youth, immigrant women, and trafficking victims. We are planning to enhance our work together to improve our ability to connect women with health care and specialized violence services; develop referral protocols; conduct cross-training of staff; and collaborate on policy initiatives at the city and state levels to improve laws and services for victims of violence.

Sanctuary for Families is extremely supportive of the innovative work of PPNYC's Intimate Partner Violence Screening in Reproductive Health Centers Program. Please contact me if you have any questions regarding this letter of support. We thank you for your commitment to programs that aim to find strategies to end domestic violence, and this wonderful opportunity to nominate PPNYC's program for a Mary Byron Project Celebrating Solutions Award.

Sincerely,

Laurel Eisner
Executive Director

Address: PO Box 1406 Wall Street Station New York, NY 10268
Email: leisner@stfny.org
Phone: 212-349-6009
August 1, 2011

Celebrating Solutions Awards
Mary Byron Project, Inc.
10401 Linn Station Road, Suite 116
Louisville, KY 40223

Dear Members of the Awards Committee:

I am pleased to support the nomination of Planned Parenthood of New York City's (PPNYC's) Intimate Partner Violence Screening in Reproductive Health Centers Program for a Mary Byron Project Celebrating Solutions Award.

In New York City, as in most communities, intimate partner violence (IPV) remains a pervasive problem that needs to be addressed on many levels. In 2010, the New York City Police Department responded to 249,440 domestic violence incidents, and the city's Domestic Violence Hotline answered more than 320 calls per day. However, numerous cases of domestic violence go unreported; for example, 77% of domestic homicides had no prior police contact. It is crucial that professionals are trained to appropriately identify and address IPV in everyday settings, such as health care centers, schools, and social service programs.

Through its three health centers in the Bronx, Brooklyn, and Manhattan, PPNYC provides a comprehensive array of sexual and reproductive health services to more than 49,000 clients annually. As one of New York City's largest reproductive health care providers, PPNYC has been on the forefront of incorporating screening for IPV as a part of routine health visits, as well as developing specific follow-up procedures and training for health center staff. Recognizing the link between women's health and violence, PPNYC began integrating IPV screening into its protocols in 1998, and tested and modified the screening questions through two research grants between 2003 and 2009. These studies resulted in PPNYC's evidence-based IPV screening program – from design to implementation to evaluation of its efficacy. The program allows for research on the association between IPV and reproductive health concerns, as well as collaboration with community-based IPV agencies to connect women with service providers for comprehensive social, legal, and health services.

This important recognition of the PPNYC's Intimate Partner Violence Screening in Reproductive Health Centers Program by the Mary Byron Project would benefit the thousands of women, men, and youth who access PPNYC's clinical services annually, and I strongly support this nomination. If you have any questions regarding this letter of support, please feel free to contact me.

I thank you for this opportunity to honor the groundbreaking work of PPNYC to provide evidence-based screening protocols in its health centers, as well as build stronger connections between health care agencies and IPV-related organizations.

Sincerely,

Liz Krueger
New York State Senator
liz@lizkrueger.com