Opinion: Social workers need to remove barriers for intimate partner violence screenings

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Homicide is a leading cause of death among women who are pregnant and within 1 year postpartum in the US, with Louisiana of particular concern. Most of these cases involve intimate partner violence (IPV), which is known to escalate during pregnancy.

Dr. Maeve Wallace (University of Arizona) and I recently received a $163,000 grant from the National Institute of Child Health and Human Development to understand the optimal role of health and social service providers in supporting peripartum

people who experience IPV. Our overall objective is to understand, from the perspective of survivors of violence and health care providers, the barriers to and preferences for increasing IPV screening and supports in maternity care settings. In the long-term, we hope our findings will inform future interventions – and public policy to bolster – improved provider and system-level responses for pregnant and postpartum women experiencing IPV.

A range of health care providers encounter pregnant and postpartum people, including OB/GYNs, nurses, pediatricians, midwives, doulas, lactation consultants, and emergency department physicians; social workers are leaders in or at minimum connected to all of these teams. As the recent work of Reiley Reed and others highlights, pregnant and postpartum people may withhold IPV experiences for fear of being reported to state child welfare agencies (i.e., mandated reporting), reported within a healthcare system, or overall stigma. The legacy of family policing goes back to colonialism, slavery, ableism, and classism, overlapping with IPV today where marginalized people experience not only subpar maternity care but also heightened concerns about the negative consequences of child protective services (CPS) involvement.

CPS involvement and mandated reporting in cases of IPV fits squarely within the practice of social work; social workers at all levels of our profession must work to create a system where people experiencing violence feel supported, not surveilled or punished, when they reach out. One way this could happen is social workers taking the reins to design and host interprofessional education (alongside survivors, midwives, doulas, OB/GYNs, etc.) where providers can learn not only how to screen for IPV, but how screening and the supports it does (or doesn’t) offer fit into larger political, economic, and social structures. We can also co-create (with survivors) peer education and training in the reforms or alternatives to CPS that survivors envision in health and social services.

Hopefully, our emerging findings will support this effort at a time when peripartum people urgently need their voices heard.

Dr. Margaret Mary Downey is an Assistant Professor at Tulane University’s School of Social Work with a focus on the social and structural determinants of health

inequities, particularly those in reproductive and maternal health. Her research interests include the role of health-related social workers as street-level bureaucrats and structural competency, an emerging education paradigm that trains health professionals in understanding the relationships among race, class, the embodiment of health inequities at the patient level, and symptom expression. Her current work uses critical ethnographic methods to examine how frontline health workers understand and intervene upon racial and economic reproductive and maternal health inequities.

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