



Responding to Intimate Partner Violence in the Perinatal Period

A Toolkit for Perinatal Healthcare Providers

The Colorado
Perinatal Care
Quality
Collaborative



This toolkit was developed by the Colorado Perinatal
Care Quality Collaborative (CPCQC) in collaboration
with the CPCQC Interpersonal Violence Taskforce

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INTRODUCTION

Intimate Partner Violence in the Perinatal Period

Intimate partner violence (IPV) is a significant public health issue that affects individuals across all communities. [The Centers for Disease Control and Prevention](#) (CDC) defines IPV as physical violence, sexual violence, psychological aggression, stalking, coercive control, and other behaviors used by a current or former partner to establish power and control.

IPV does not affect all communities equally. While anyone can experience violence, historical and ongoing inequities in healthcare access, economic opportunity, housing stability, discrimination, immigration-related concerns, disability status, social isolation, and barriers to support contribute to increased vulnerability and more severe consequences for some populations. National data demonstrate these disparities: nearly 1 in 2 Black women (45.1%) and more than 2 in 5 multiracial women (54.8%) report experiencing contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime ([Smith et al., 2018](#)). Additionally, individuals with disabilities experience disproportionately high rates of violence, with research estimating they are approximately 1.5–2 times more likely to experience IPV compared with individuals without disabilities ([Hughes et al., 2012](#)). These inequities may be further intensified during pregnancy and the postpartum period, when increased healthcare contact, financial stressors, dependence on partners, changing family dynamics, and barriers to accessing safe support can heighten risk and create additional challenges to disclosure and safety.

For individuals during pregnancy and the postpartum period, IPV poses unique and serious risks. The perinatal period can be a time when violence begins or escalates, placing both the birthing person and infant at increased risk for poor health outcomes. [The Colorado Department of Public Health and Environment](#) reports that approximately 1 in 3 women experience physical, emotional, or sexual abuse in their lifetime, and those affected are more likely to experience delayed prenatal care, depression, substance use, preterm birth, low birth weight, and challenges with postpartum recovery and maternal-infant bonding.

The outcomes of IPV can be devastating. Nationally, homicide is one of the leading causes of death during pregnancy and the first year postpartum, with many of these deaths linked to IPV. Findings from maternal mortality review committees, including [Colorado's](#), continue to highlight violence and behavioral health concerns as critical contributors to pregnancy-associated deaths and severe maternal morbidity.

Healthcare teams are uniquely positioned to identify IPV, respond with compassion, and connect patients to meaningful support if and when the patient is ready.

Why This Toolkit Was Created

Despite clear recommendations, barriers such as inconsistent workflows, lack of training, discomfort initiating conversations, and limited awareness of available resources can make effective response to IPV disclosure challenging for clinical and community-based healthcare teams.

This toolkit was developed to support clinical and community-based healthcare teams in delivering consistent, trauma-informed, patient-centered care for patients experiencing or at risk of IPV. The toolkit provides practical guidance, tools, and resources to strengthen screening practices, improve response to disclosure, standardize referral pathways, and build confidence in supporting patients safely and effectively.

Every interaction is an opportunity to create safety, foster trust, and connect patients with life-saving support. By strengthening our response to IPV, we can improve maternal outcomes and help ensure every patient feels seen, heard, and supported throughout pregnancy and postpartum.



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We extend our deepest gratitude to the members of CPCQC's Interpersonal Violence (IPV) Task Force, whose expertise, dedication, and passion made this toolkit possible. Their willingness to share their knowledge, expand our conversations, and lend their voices to this work has been invaluable.

This toolkit is the result of a collective commitment to improving how healthcare teams recognize and respond to IPV in the perinatal period. Each conversation, recommendation, review, and thoughtful contribution helped shape a resource that we hope will strengthen care, improve safety, and create meaningful change for patients and families across Colorado.

To the IPV Task Force members: Thank you for your time, collaboration, and unwavering commitment to advancing trauma-informed, patient-centered care. Your work is helping build a future where clinical and community-based healthcare providers are better equipped to recognize risk, respond with compassion, and connect patients to the support they deserve.

CPCQC is deeply grateful for your partnership and for the impact your contributions will have on the lives of countless patients and families.

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WHAT'S INCLUDED IN THIS TOOLKIT

IPV READINESS ASSESSMENT

Assess your site's current approach to IPV education, screening, and response using this standardized assessment. This assessment is designed to help you pinpoint strengths, uncover opportunities for growth, and determine where to begin implementing changes so your site and staff are better equipped to respond to and navigate IPV in the healthcare setting.

Begins on page 6

RESOURCE LIBRARY

Once you have identified areas for education and improvement, use the resources provided to strengthen your team's knowledge and build your site's readiness to effectively recognize, respond to, and navigate IPV in the healthcare setting.

Begins on page 7

IMPLEMENTATION CHECKLIST

Use this checklist to guide the changes your team is implementing. It's important to approach this work with structure—clearly identifying who will be responsible, how each change will be carried out, and the timeline for completion.

Begins on page 14



HOW TO USE THIS TOOLKIT

1

COMPLETE THE IPV READINESS ASSESSMENT

Complete the IPV Readiness Assessment with a multidisciplinary team

2

DETERMINE PRIORITY FOCUS AREAS

Use assessment results to select the highest-impact areas for improvement (as identified in red or yellow boxes).

3

ACCESS THE RESOURCE LIBRARY TO SUPPORT IMPROVEMENT

Access Resource Library materials that match your identified needs.

4

USE THE IMPLEMENTATION CHECKLIST TO SUPPORT ACTION

Use the Implementation Checklist to communicate across your team and set realistic improvement goals

IPV READINESS ASSESSMENT

Please use this tool to see where your unit sits in Intimate Partner Violence (IPV) awareness and implementation. This can help guide you on where to start implementation.

	The practice is in early development or has not yet been implemented.
	The practice is underway but not yet consistently or reliably integrated into unit workflows.
	The practice is fully integrated into routine care delivery and supported by systems that promote long-term sustainability.

	BUILDING FOUNDATIONS	GAINING TRACTION	SUSTAINED PRACTICE
System Needs			
Does your site have IPV screening and response policies consistent with evidence based recommendations and state laws? Audit tool			
Does your site have validated IPV screening tools integrated into your EHR?			
Does your site have an established safety plan for staff when navigating IPV?			
Does your site have a readily available resource map of local, state, and national organizations that support those experiencing IPV?			
Does your site train staff on workplace violence prevention and response?			
Does your site have guidelines related to safety planning when a patient discloses IPV? Does it account for if an infant is involved as well?			
Does your site have a team of staff members who have been trained in safety planning for patients impacted by IPV?			
Does your site have resources to support your staff experiencing secondary trauma (an emotional stress response that occurs when you are indirectly exposed to another person's firsthand trauma)?			
Are all your IPV resources (screeners and flyers) translated to meet the needs of your sites' patient population? Or a plan to support interpretation needs as needed?			
Staff Education			
Does your staff feel prepared to screen and respond to IPV? Use this survey to gauge how prepared your staff are to screen and respond to IPV			
Does your site provide standardized staff education on mandatory reporting?			
Does your site provide standardized staff education on IPV screening and response?			
Does your site provide standardized staff education on trauma informed care?			
Does your staff know safe documentation best practices for IPV?			
Patient Resources			
Does your site have patient-facing resources for patients who disclose IPV? These resources should be easily accessible, provided in many languages, and updated at least annually. Examples of these resources include: transportation, financial support, safe houses that take infants, and social services.			

RESOURCE LIBRARY

Once your team completes the IPV Readiness Assessment, use the results to guide your improvement priorities. The Resource Library provides IPV-specific tools and strategies to address your identified gaps. For example, if your staff are unaware when a mandatory report is required, the Resource Library includes resources for education related to mandatory reporting.

SYSTEM NEEDS

TOPIC	RESOURCE
Does your site have policies consistent with evidence based recommendations and state laws?	• Colorado Mandatory Reporters Training Module • ACOG Committee Opinion on IPV • AWHONN position statement on IPV • Guidance for Mandatory Reporting when the patient is over the age of 18 and not considered an "at-risk" adult
Does your site have validated IPV screening tools integrated into EHR? Tools should be available in minimum the top 3 languages at your hospital	• List of validated screening tools
Does your site have an established safety plan for staff when navigating IPV.	• Joint Commission Workplace Safety and Wellbeing Plan • OSHA Caring for our Caregivers
Does your site have a readily available resource map of local, state, and national organizations that support those experiencing IPV?	• CPCQC Building Partnerships handout • Violence Free Colorado • You Have the Right Colorado • National Domestic Violence Hotline call: 1-800-799-7233 text: BEGIN to 88788
These resources should be easily accessible and updated at least annually.	
Are they translated to meet the needs of your patient population?	* Remind your patients that the hospital phone is a safe phone to use. It cannot be tracked by their partner. *

SYSTEM NEEDS CONTINUED

TOPIC	RESOURCE
Does your site have guidelines related to safety planning or staff members trained in performing safety planning? *This can be referred out to a local organization, but your staff must know who to call and when they are available*	• CPCQC safety planning template Colorado-based organizations that can support safety planning • SPAN • Rose Andom Center • SAVA • Prochlight- Jeffco • Servicios De La Raza • Family Tree- Denver Metro • DOVE Center
Does your site have resources to support your staff experiencing secondary trauma (an emotional stress response that occurs when you are indirectly exposed to another person's firsthand trauma)	• ASPR TRACIE Disaster Behavioral Health Self-Care for Healthcare Workers Modules • SMAHSA Self-Care for Healthcare Workers • Employee Assistance Programs • National Child Trauma Stress Network Tools

STAFF EDUCATION

TOPIC	RESOURCE
Does your site provide standardized staff education on mandatory reporting?	• CPCQC Mandatory Reporting Matrix • Colorado Mandatory Reporters Training Module • Child abuse (ages 0-17) training
Does your site provide standardized staff education on IPV screening and response?	• CPCQC IPV training flyer • CUES • World Health Organization LIVES
Does your site provide standardized staff education on trauma informed care ?	• Trauma and the Brain- helpful video for understanding how trauma impacts the brain • CPCQC IPV training flyer
Are your staff prepared to screen and respond to IPV?	• CPCQC Navigating Intimate Partner Violence (IPV) For healthcare providers one-pager • PEARR communication tool • Therapists Aid- What is Domestic Abuse? • Timeline of Hospital Criminalization
Does your staff understand the 21 st century Cures Act and safety documentation best practices?	• Privacy Principles for Protecting Survivors of Intimate Partner Violence, Exploitation and Human Trafficking in Healthcare Settings • 21st Century CURES Act: A Summary and Recommendations to Promote Patient Privacy for Survivors • A Practical Guide on Intimate Partner Violence, Human Trafficking, and Exploitation and Technology Tools
Does your staff have the ability/understand how to make charting confidential?	
Where does your staff document if a Mandatory report was made?	

PATIENT RESOURCES

TOPIC	RESOURCE
Does your site have a standardized workflow for IPV resource sharing for all families (universal distribution)? These resources should be easily accessible and updated at least annually. Resources should be available in multiple languages.	• CPCQC patient-facing IPV handout ** We recommend this flier be displayed in all patient bathrooms and in public bathrooms** ◦ English ◦ Spanish • National Council for Community Behavioral Healthcare Patient bill of rights • Power and control wheel- general • Power and control wheel- LGBTQ+ • Consent FRIES • Gaslighting worksheet **You do not have to share all these resources universally, but this is a variety of helpful options to choose from**
Does your site have patient-facing resources for patients who disclose IPV? These resources should be easily accessible and updated at least annually.	• You have the right • Safe Leave CO • HB25-1168 Housing protections for survivors. • HB25-1185 Child Conceived from Sex Assault Proceedings • Victim Compensation • My plan App
Consideration for specific populations **make sure this is specific to your patient population**	• LGBTQ Domestic Violence Awareness Foundation • Human Rights Campaign • The Links Between Disability & Domestic Violence • Abused Deaf Women's Advocacy Services • The National Center on Violence Against Women in the Black Community • National Indigenous Women's resource Center • Servicios De La Raza

HUMAN TRAFFICKING

While human trafficking and IPV are distinct forms of abuse, they can overlap and are sometimes mistaken for one another because both involve power, control, coercion, and fear. Human trafficking is the use of force, fraud, or coercion to compel a person into labor or commercial sex acts. In healthcare settings, trafficking may present through signs that can resemble IPV, including restricted communication, controlling companions, unexplained injuries, fearfulness, inconsistent histories, or limited autonomy in decision-making.

Pregnant and postpartum individuals may be particularly vulnerable due to financial dependence, housing instability, immigration concerns, substance use, or limited social support. Studies have found that as many as 88% of trafficking survivors accessed healthcare during their exploitation, creating critical opportunities for identification and intervention ([Polaris, 2018](#)). Pregnancy itself may also be used as a mechanism of control, and survivors of trafficking experience higher rates of inadequate prenatal care, poor maternal outcomes, and trauma-related health complications ([American College of Obstetricians and Gynecologists, 2013](#)).

Because trafficking can present similarly to IPV—but often requires different safety considerations, reporting pathways, and community resources—it is essential that healthcare teams understand how to recognize potential indicators and respond appropriately.

The following resources are designed to support your team in identifying concerns, responding in a trauma-informed manner, and connecting patients with specialized support services.

TOPIC	RESOURCE
Human Trafficking in a Healthcare Setting: A Comprehensive Toolkit	Toolkit from the Laboratory to Combat Human Trafficking
Hotlines and Referral Resources	Colorado’s 24/7 Human Trafficking Hotline: call 1-866-455-5075 or text 720-999-9724

GUN VIOLENCE

Homicide is one of the leading causes of death during pregnancy and the postpartum period in the United States ([Wallace et al., 2021](#)). Gun violence is one of the most lethal components of IPV. The presence of a firearm in an abusive relationship increases the risk of homicide by 5 fold ([CDPHE](#)), making firearm access a critical factor in assessing danger and planning for patient safety. Research shows that when an abusive partner has access to a firearm, the risk of intimate partner homicide increases substantially. Firearms were by far the most common mechanism of injury in pregnancy-associated homicide, involved in 76% of the cases ([Wallace & Jahn, 2025](#)).

For pregnant and postpartum individuals, this risk is especially concerning. The perinatal period can be a time of increased vulnerability, as abuse may escalate during pregnancy or after birth due to heightened stress, shifting relationship dynamics, financial strain, or increased attempts by an abusive partner to exert control ([American College of Obstetricians and Gynecologists, 2012](#)).

When learning about IPV, it is essential for healthcare providers to understand the role firearms can play in escalating violence and to recognize that they can help reduce risk through thoughtful assessment, trauma-informed conversations, and connection to appropriate safety resources. Asking about safety concerns, recognizing escalating risk factors, and understanding firearm-related protective measures—such as temporary secure storage, extreme risk protection orders where applicable, and individualized safety planning—can be life-saving interventions.

The following resources are intended to help healthcare teams build awareness of firearm-related risk in IPV, strengthen assessment practices, and support patients in developing safer pathways forward.

TOPIC	RESOURCE
Discussing gun violence with patients	• Agree to Agree Campaign • Intermountain Health’s Firearm Safe Storage Talking Points for Facilities • American Medical Association: talking to patients about firearms
Gun Violence Reduction Resources	• Colorado Gun Violence Prevention Resource Bank • Institute for Firearm Injury Prevention: Resources for Healthcare Professionals • American Hospital Association: Public Health Approach to Addressing Gun Violence

STRANGULATION

Strangulation is one of the most dangerous forms of intimate partner violence (IPV), yet it often leaves little to no visible injury. Strangulation occurs when external pressure is applied to the neck, restricting blood flow, airflow, or both. Even brief episodes can cause serious injury, including loss of consciousness, brain injury, stroke, miscarriage, or death.

Non-fatal strangulation is one of the strongest known predictors of future intimate partner homicide. Research has shown that women who have had a history of non-fatal strangulation by an intimate partner increases the risk of future attempted or completed homicide by more than 7-fold ([Glass et al., 2008](#)). Healthcare providers should treat any history of strangulation as a serious medical and safety concern requiring prompt assessment and intervention.

Healthcare providers play a critical role in identifying strangulation and ensuring timely evaluation and intervention. Patients may not use the term "strangulation" and instead describe being "choked," "grabbed by the neck," or having pressure applied to their throat. Because visible injuries may be absent, it is essential to ask direct, trauma-informed questions when IPV is suspected.

Medical complications can develop hours or even days after the event. Any disclosure or suspicion of strangulation should be treated as a medical emergency requiring prompt assessment according to organizational protocols and available community resources.

By recognizing the signs of strangulation and responding appropriately, healthcare professionals can help prevent serious injury and potentially save lives.

TOPIC	RESOURCE
Recommendations for the medical evaluation	• Training Institute on Strangulation Prevention- Strangulation algorithm • IAFN Non-Fatal Strangulation Documentation Toolkit

INTERSECTION OF IPV AND MENTAL/BEHAVIORAL HEALTH

IPV is strongly associated with increased risk ([Devries et al 2013](#)) of depression, anxiety, post-traumatic stress, substance use disorders, suicidal ideation, and suicide attempts. Patients experiencing IPV may not disclose abuse directly and instead present with mental health symptoms, difficulty managing chronic conditions, missed appointments, frequent healthcare utilization, changes in behavior, or challenges with coping and recovery.

Healthcare teams may find themselves helping patients navigate concerns related to mental health, substance use, suicidal thoughts, or other psychosocial stressors without realizing these experiences may be connected to violence or coercive control. Recognizing these overlapping challenges creates opportunities to provide more comprehensive, trauma-informed care and identify underlying safety concerns that may otherwise go unnoticed.

Substance use and IPV often have a bidirectional relationship—substances may be used to cope with trauma, while substance use can also increase vulnerability to violence and create additional barriers to seeking help. Likewise, suicidal thoughts or self-harm behaviors may occur in the context of fear, isolation, coercion, or ongoing abuse. [The CDC reports](#) that individuals experiencing IPV have significantly higher rates of depression and suicidal ideation (often estimated at 2–3 times higher than those not experiencing IPV), as well as increased prevalence of substance use disorders.

When concerns for mental health, suicide risk, or substance use arise, consider IPV as a possible underlying contributing factor and screen when appropriate using a trauma-informed, patient-centered approach.

Prioritize privacy, safety, and nonjudgmental communication, and ensure patients are supported in a way that honors autonomy and acknowledges that disclosure may or may not occur. Even when IPV is not disclosed, clinicians may still be supporting patients through the downstream impacts of violence.

TOPIC	RESOURCE
Suicide prevention	• Zero Suicide Toolkit • Colorado Mental Health Line - call or text 988
Substance use support	• HardBeauty • PROSPER • Colorado Mental Health Line - call or text 988
Mental Health	• Charlie Health • Postpartum Support International • PIPER

IMPLEMENTATION CHECKLIST

- ☐ Complete IPV Readiness Assessment with a multidisciplinary team
- ☐ Identify opportunities using the IPV Readiness Assessment (red and yellow)
- ☐ Use resources from the toolkit to work on focus areas
- ☐ Hang CPCQC patient-facing and staff-facing IPV fliers in patient rooms and staff areas.
- ☐ Perform follow-up IPV Readiness Assessment within 6 months to determine progress

Focus Area	What will we do?	Who?	By when?
IPV Readiness Assessment			
Identify focus areas			
Educate/train staff with resources from toolkit			
Ensure universal education and screenings for patients is provided at your site			
Hang CPCQC patient-facing and staff-facing IPV fliers in patient rooms and staff areas.			
Perform follow-up IPV Readiness Assessment to determine progress and ongoing needs.			

REFERENCES

1. Glass, N., Laughon, K., Campbell, J., Block, C. R., Hanson, G., Sharps, P. W., & Taliaferro, E. (2008). Non-fatal strangulation is an important risk factor for homicide of women. *Journal of Emergency Medicine*, 35(3), 329–335.
2. Wallace, M. E., & Jahn, J. L. (2025). Pregnancy-Associated Mortality Due to Homicide, Suicide, and Drug Overdose. *JAMA network open*, 8(2), e2459342.
<https://doi.org/10.1001/jamanetworkopen.2024.59342>
3. American College of Obstetricians and Gynecologists. (2012). Intimate partner violence (Committee Opinion No. 518). *Obstetrics & Gynecology*, 119(2, Part 1), 412–417.
<https://doi.org/10.1097/AOG.0b013e318249ff74>
4. Wallace M, Gillispie-Bell V, Cruz K, Davis K, Vilda D. Homicide During Pregnancy and the Postpartum Period in the United States, 2018-2019. *Obstet Gynecol*. 2021 Nov 1;138(5):762-769. doi: 10.1097/AOG.0000000000004567. Erratum in: *Obstet Gynecol*. 2022 Feb 1;139(2):347. doi: 10.1097/AOG.0000000000004671. PMID: 34619735; PMCID: PMC9134264.
5. Anthony, B. (2018). On-ramps, intersections, and exit routes: A roadmap for systems and industries to prevent and disrupt human trafficking—Health care. Polaris.
<https://polarisproject.org/resources/on-ramps-intersections-and-exit-routes/>
6. American College of Obstetricians and Gynecologists. (2013). Reproductive and sexual coercion. Committee Opinion No. 554. *Obstetrics & Gynecology*, 121(2 Pt 1), 411–415.
<https://doi.org/10.1097/01.AOG.0000426427.79586.3b>
7. Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., & Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, 379(9826), 1621–1629
8. Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., Astbury, J., & Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLOS Medicine*, 10(5), e1001439.
9. Colorado Department of Public Health and Environment. (n.d.). Intimate partner violence. Colorado Gun Violence Prevention Resource Bank. <https://cdphe.colorado.gov/colorado-gun-violence-prevention-resource-bank/injury-and-death-involving-firearms/intimate-partner>

