|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| Bair-Merritt et al, 2010107 | Randomized controlled trial comparing whether mothers receiving home visitation after giving childbirth had changes in IPV vs. those who did not receive home visitation | 897 eligible; 685 randomized | English-speaking mothers in Oahu, Hawaii hospitals who gave birth to an infant evaluated as at risk for maltreatment; 33% Hawaiian/Pacific Islander, 28% Asian Filipino, 37% white | Recruitment from 6 hospitals in Oahu, Hawaii. Intervention provided in home of mother/care provider | Interviews within 1 week post-birth, annually when child wasages 1 to 3 years, and annually when child was ages 7 to 9 years | Conflict Tactics Scale 1 (CTS1) at baseline; CTS2 at subsequent data points with 4 sexual coercion questions omitted. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Women at 6 hospitals in Oahu, Hawaii who gave birth between November 1994 and December 1995 | Families who gave birth Nov 1994 to Dec 1995 in Oahu, had an English-speaking mother, were not involved with protective services and had an infant assessed at high risk for maltreatment | Home visitation with goal of promoting child health and decreasing child maltreatment by linking families to appropriate community services, teaching about child development, role-modeling positive parenting and problem-solving strategies, and offering emotional support. Intervention offered by 3 community agencies. Mean of 13.6 visits in first year. | During program, intervention mothers had lower rates of IPV victimization (incidence rate ratio [IRR] 0.86 [95% CI, 0.73-1.01]) and lower rates of perpetration (IRR, 0.83 [95% CI, 0.72-0.96]). Mothers receiving intervention had lower rates of physical assault victimization (IRR, 0.85 [95% CI, 0.71-1.00]) and perpetration (IRR, 0.82 [95% CI, 0.70-0.96]). Long-term followup rates of overall IPV victimization and perpetration decreased with nonsignificant between-group differences. Verbal abuse victimization rates may have increased in intervention mothers (IRR, 1.14 [95% CI, 0.97-1.34]). | Fair |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| Curry et al, 2006108 | Randomized controlled trial comparing an offer to watch an abuse video and receive 24-hour individualized nursing case management vs. no intervention control on stress levels of pregnant women at risk for or in abusive relationships | 1649 eligible; 1000 randomized | English-speaking women aged 14-46 years who were 13 to 23 weeks pregnant at 2 prenatal clinics. Pacific NW HMO clinic: Caucasian 67.6%, African American 16.2%, Hispanic 4.4%, Asian/Pacific Islander 3.8%, Native American 1.2%. Rural midwestern university clinic: 82%, 12.2%, 1.4%, 2.6%, and 0%, respectively. | Prenatal clinics: 1 Pacific NW HMO, 1 rural midwestern university clinic | From early pregnancy (before week 23) to delivery. Duration data not provided; up to 7-8 months is assumed. 1st assessment prior to 23 weeks of pregnancy, 2nd between 32 weeks and delivery. | 3 questions from the Abuse Assessment Screen (AAS); Prenatal Psychosocial Profile (PPP). Risk for abuse determined by response from the 3 AAS questions and to 1 PPP question asking how stressed the respondent is regarding current physical, sexual, or emotional abuse. Scores of 24 or more on the PPP stress scale were determined to indicate high risk. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Pregnant adolescents and women presenting at 2 prenatal clinics from 2001 through 2003. | English-speaking adolescents and women 13 to 23 weeks pregnant who presented at 2 prenatal clinics. | Offer to view abuse video and access nurse case manager 24/7. Intervention participants were classified as low or high risk. Those who were actively case-managed received individual, comprehensive assessment to develop a care plan. Intervention categories: support, assess, educate, monitor, coordinate and coach. All were offered a card with safety and abuse recognition info, with numbers for national and local DV resources. | Total stress scores of high-risk case-managed participants decreased significantly (p<0.001). Item and total stress scores of high-risk control participants also decreased, and differences between intervention and control were not significant. For both intervention and control, only the item related to pregnancy stress increased between T1 and T2. For both groups, total scores and all item scores, except pregnancy stress, were significantly lower at T2. | Poor |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| El-Mohandes et al, 2008109 (NIH-DC Initiative to Reduce Infant Mortality in Minority Populations) | Randomized trial comparing a clinic-based individually-tailored behavioral intervention with usual care to evaluate the effectiveness of an integrated multiple-risk intervention for pregnant women in reducing risks, including IPV, postpartum | 1398 eligible;1070 randomized | English-speaking, pregnant African American women presenting at 6 prenatal care sites in the District of Columbia. | 6 prenatal care sites in the District of Columbia | Interviews at baseline, presumably in the first trimester, with followup interviews at 22-26 weeks’ gestation, 34-38 weeks’ gestation, and at an average 10.3 weeks postpartum | Audio-Computer Assisted Survey Interview screening. For IPV, women were asked if a current or previous partner, boyfriend, husband, or the baby’s father had pushed, shoved, slapped, kicked, or physically hurt them or forced them to have sexual intercourse in the last year, or if they were afraid of their current partner. The baseline interview included the Conflict Tactics Scale. IPV was confirmed if a woman reported being subjected to any of the actions on the revised Conflict Tactics Scale at least once by her partner in the last year. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Pregnant African American women seeking health care at 6 prenatal care sites in the District of Columbia between July 2001 and October 2003 | African American women aged ≥18 years and at 28 weeks or less of pregnancy, DC residents, English speaking, and reporting 1 of 4 designated risks: active smoking, environmental toxic smoke exposure, depression or IPV. | IPV intervention was adapted from the Parker-McFarlane structured intervention to individualized counseling. Behavioral counseling for IPV was integrated from a brochure-based approach using Dutton’s empowerment theory. The intervention was intended to be delivered prenatally for a minimum of 4 sessions, with 8 sessions considered ideal. Up to 2 postpartum booster sessions were offered. The intervention was offered by Master's degree trained counselors. Prenatal sessions lasted 36±15 minutes per session, with an average of 3.9 sessions. Postpartum sessions lasted 38±13 minutes per session, with an average of 0.8 sessions. 46% of participants did not receive minimum number of intervention sessions. | IPV reduced from 36.8% to 9.9% between baseline and post-partum (p<0.001). No significant differences in change in IPV between intervention and control groups. | Fair |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| El-Mohandes et al, 201129 (NIH-DC Initiative to Reduce Infant Mortality in Minority Populations) | Randomized trial comparing a clinic-based individually-tailored behavioral intervention with usual care to evaluate the effectiveness of an integrated multiple-risk intervention for pregnant women in reducing risks, including IPV, postpartum | 1044 randomized; 819 analyzed (live, singleton, birth outcomes available) | English-speaking, pregnant African American womenMaternal age: 18-22 (43%), 23-27 (31%), 28+ (27%)Single/separated/widowed/divorced: 75%Medicaid: 79%Income <$2000/month: 71%Prior IPV: 32% | 6 prenatal care sites in the District of Columbia | Interviews at baseline, presumably in the first trimester, with followup interviews at 22-26 weeks’ gestation, 34-38 weeks’ gestation | Audio-Computer Assisted Survey Interview screening was used to screen for risk factors, pregnancy status, and demographic eligibility. Additional questions asked during a telephone interview. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Author, Year** | **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| El-Mohandes et al, 201129 (NIH-DC Initiative to Reduce Infant Mortality in Minority Populations) | Pregnant African American women seeking health care at 6 prenatal care sites in the District of Columbia between July 2001 and October 2003. | African American women aged ≥18 years and at 28 weeks or less of pregnancy, DC residents, English speaking, and reporting 1 of 4 designated risks: active smoking, environmental toxic smoke exposure, depression or IPV. | Designed to occur during prenatal care (immediately after visits) for 8 discrete sessions lasting 35+15 minutes (actually received 1.7-7.1 sessions). IPV intervention was adapted from the Parker-McFarlane structured intervention to individualized counseling. Behavioral counseling for IPV was integrated from a brochure-based approach using Dutton's empowerment theory. Smoking and depression were also addressed. | Very preterm birth (significant): 2.2% (9/402) intervention group vs. 5.0% (21/416) usual care group (OR, 0.43 [95% CI, 0.20-0.95]; NNT=36 mothers)Very low birth weight (not significant): 1.0% (4/402) intervention group vs. 2.2% (9/415) usual care group (OR, 0.45 [95% CI, 0.14-1.48]); NNT=83 mothers)IPV recurrence: 7.9% intervention group vs. 21.6% usual care group (p=0.04)Among women reporting no risks (smoking, environmental toxic smoke exposure, depression, IPV) at baseline, more women in usual care group than intervention group reported risks during the last followup interview (p=0.04)Women randomized to intervention group reported a significant reduction in risks if they reported 1-2 risks at baseline (p=0.21), but not if they reported 3-4 risks (p=0.383). | Fair |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| Kiely et al, 201030 (NIH-DC Initiative to Reduce Infant Mortality in Minority Populations) | Randomized trial of counseling interventions during pregnancy and postpartum vs. usual care for recurrent IPV | 1398 eligible; 1044 randomized | English-speaking, pregnant African American women Mean age: 24.5 years% Medicaid: 79%336 (32%) reported prior IPV | 6 prenatal care sites in the District of Columbia | Interviews at baseline, presumably in the first trimester, with followup interviews at 22-26 weeks’ gestation, 34-38 weeks’ gestation, and 8-10 weeks postpartum | Interviews at baseline with followup interviews at 22-26 weeks’ gestation, 34-38 weeks’ gestation, and 8-10 weeks postpartum. Used the Abuse Assessment Screen and the Conflict Tactics Scale. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Pregnant African American women seeking health care at 6 prenatal care sites in the District of Columbia between July 2001 and October 2003. | African American women aged ≥18 years and at 28 weeks or less of pregnancy, DC residents, English speaking, and reporting 1 of 4 designated risks: active smoking, environmental toxic smoke exposure, depression or IPV. | Prenatal behavioral counseling for 4-8 sessions, with up to 2 postpartum sessions provided by professional counselors. IPV counseling emphasized safety behaviors and information on community resources. Smoking and depression were also addressed. | Women in the intervention group had less recurrent episodes of IPV during pregnancy and postpartum (OR, 0.48 [95% CI, 0.29-0.80]); fewer very preterm neonates (1.5% vs. 6.6%; p=0.03), and increased mean gestational age (38.2 vs. 36.9 weeks; p=0.016).  | Good |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| McFarlane et al, 2006110 | Randomized, 2-arm trial comparing wallet-sized referral card and 20-min nurse management protocol for prevention of IPV with 360 abused women | 433 eligible;360 randomized | English- or Spanish-speaking women aged 18 to 45 presenting for clinic care. Caucasian: 11.9%Black: 27.9% Hispanic: 59.6% | 2 primary care public health clinics and 2 WIC clinics in a large urban area | Interviews at baseline and at 6, 12, 18, and 24 months post-baseline | 2 questions from the Abuse Assessment Screen. Those with a positive response to item 1 or 2 were invited to participate. Outcomes were measured with the Safety Behavior Checklist (with an adjustment procedure), the Community Resource Checklist, The Severity of Violence Against Women Scale (SAVAWS), the Danger Assessment Scale, and the Employment Harassment Questionnaire. Baseline measures asked about the preceding 12 months; subsequent measures asked about the time period since the previous interview. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Women aged 18 to 45 presenting at 2 primary care and 2 WIC clinics in a large urban area from February 2001 to June 2002. | Women aged 18 to 45 assessed as positive for physical or sexual abuse in the past 12 months. | 1) Wallet-sized referral card with a safety plan and sources for IPV services or2) 20-minute nurse case management protocol (March of Dimes) including a brochure with a 15-item safety plan, supportive care, anticipatory guidance, and guided referrals. | 2 years after treatment, both groups reported fewer threats of abuse (p<0.001) (M=14.5 [95% CI, 12.6-16.40]), assaults (M=15.5 [95% CI, 13.5-17.4]), danger risks for homicide (M=2.6 [95% CI, 2.1-3.0]), and events of work harassment (M=2.7 [95% CI, 2.3-3.1]), but there were no significant differences between groups. Compared with baseline, both groups adopted more safety behaviors by 24 months (M=2.0 [95% CI, 1.6-2.3]). Community resource use declined for both groups (p<0.001; M= -0.2 [95% CI, -0.4 to -0.2]). There were no significant differences between groups. | Fair |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| Miller et al, 2011111  | Cluster randomized trial of counseling intervention versus usual care | 1337 eligible; 906 participated | English- or Spanish-speaking women aged 16-29 years.16-24 years: 76%25-29 years: 24%White: 22.9%Black: 27.9%Hispanic: 29.7%Asian Pacific Islander: 12.9% | 4 urban family planning clinics in California  | 12-24 months post-intervention | Randomized to intervention or usual care via clinic attended. Computer-assisted followup survey between 12-24 weeks after baseline survey. Surveys included items from the Conflict Tactics Scales 2 and Sexual Experiences Survey, questions about awareness and recent use of IPV services, and relationship changes from baseline. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Women presenting to family planning clinics from October 2008 to May 2009 | English- or Spanish- speaking women aged 16-29 years attending 4 urban family clinics in Northern California | 1) Intervention clinics: counseling intervention that educates patients about reproduction coercion and provides information about local IPV and sexual assault resources.2) Usual care clinics: includes responding to 2 IPV screening questions on a routine intake form using a standard clinic protocol. | Intervention women with recent IPV had decreased pregnancy coercion at followup compared with usual care (adjusted OR, 0.29 [95% CI, 0.09-0.91]). Intervention women were also more likely to discontinue an unhealthy or unsafe relationship compared with usual care (p=0.013). | Fair |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Author, Year** | **Study design** | **N** | **Population** | **Setting** | **Duration** | **Screening assessment** |
| Taft et al, 2011112 (Taft 2009 protocol and methods described) | Cluster randomized trial of mentor support vs. usual care | 215 eligible; 174 participated | English- or Vietnamese-speaking mothers, ≥16 years, who were pregnant or had at least 1 child, who disclosed IPV or had behavioral symptoms suggestive of abuse.  | Primary care clinics in Melbourne, Australia | 12 months | Abuse measured by the Composite Abuse Scale (CAS), depression (Edinburgh Postnatal Depression Scale), wellbeing (SF-36), parenting stress (PSI-SF), and social support (MOS-SF) at baseline and followup. |
| **Recruitment** | **Inclusion criteria** | **Intervention** | **Results** | **Quality rating** |
| Consecutive, eligible women presenting to primary care clinics in Melbourne from January 2006 to December 2007, recruited by clinicians | English- or Vietnamese-speaking mothers, ≥16 years, who were pregnant or had at least 1 child, who disclosed IPV or had behavioral symptoms suggestive of abuse. Serious mental illness excluded. | 1) 12 months of weekly home visits from trained nonprofessional mentors offering advocacy, parenting support, and referrals.2) Usual care. | Abuse scores were significantly reduced in intervention vs. comparison groups (adjusted difference, -8.67 [95% CI, -16.2 to -1.15]). Other differences were not significant (depression, physical wellbeing, mental wellbeing, parenting stress). | Fair |

Abbreviations: A-CASI = audio-computer assisted survey interview; AAS = Abuse Assessment Screen; CAS = Composite Abuse Scale; CI = confidence interval; CTS = Conflict Tactics Scale; DV = domestic violence; HMO = health maintenance organization; IPV = intimate partner violence; IRR = incidence rate ratio; NW = northwest; OR = odds ratio; PPP = Prenatal Psychosocial Profile; PSI-SF = Parenting Stress Interview-Short Form; SAVAWS = Severity of Violence Against Women Scale; WIC = Women, Infants, and Children.