



State of Delaware

Domestic Violence

Resource Manual for Healthcare Professionals



*Prepared by the Domestic Violence Coordinating Council
www.dvcc.delaware.gov
2011 Revised Edition*

If you are in danger, please call 911.

Domestic Violence/Rape Crisis 24 - Hour Hotline Numbers

New Castle County

Domestic Violence	302-762-6110
Rape Crisis	302-761-9100

Northern Kent

Domestic Violence	302-678-3886
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Kent & Sussex

Domestic Violence	302-422-8058
Rape Crisis	800-262-9800
Bi-lingual Hotline	302-745-9874

DVCC Main Office

Phone: 302-255-0405
Fax: 302-255-2236

DVCC Kent & Sussex County Office

Phone: 302-424-7238
Fax: 302-424-5311

Information Available

www.dvcc.delaware.gov

24-Hour Hotline Numbers
State Domestic Violence Policy
Dynamics of DV
Legislation
Publications
DV Resources
Related Links



Message from the Chair

Domestic violence remains a challenge to both the medical community and our patients. Although long viewed as a social ill, domestic violence diminishes our ability to deliver effective care and is often the root cause of many common problems we encounter as care providers. These common problems can include headache, pain syndromes, noncompliance of medication plus multiple emergency room visits.

Unfortunately, domestic violence may effect as many as 33% of female patients and their children and up to 7.4% of male patients.

The purpose of this manual is to help providers recognize domestic violence; feel comfortable in screening for domestic violence and most importantly provide resources for domestic violence victims. These approaches do not require much time but can lead to a meaningful change in our care of domestic violence victims.

This manual covers important requirements regarding state reporting. Specifically, it addresses when reporting is required and why it is best to let the victim decide whenever it is legally permissible. It is important to recognize that the most likely time a homicide occurs is when the victim tries to leave his/her abuser. It is for this reason most experts, in addition to the State of Delaware, have not endorsed a universal mandatory reporting law but rather an approach of supporting men or women by providing the resources to help them safely leave a relationship in a time and manner of their choosing. Unfortunately, nobody knows the violent tendencies of his/her abuser better than a victim of domestic violence.

Additionally, this manual will cover the Affordable Care Act. This health insurance reform legislation signed into law by President Obama requires that screening and counseling for interpersonal and domestic violence must be covered without cost sharing in the first plan year which begins on or after August 1, 2012.

Along with the Domestic Violence Coordinating Council, I would like to acknowledge the following for their assistance in writing this manual: Members of the DVCC Medical Subcommittee and the Sexual Assault Network of Delaware (SAND). The Domestic Violence Coordinating Council's Medical Subcommittee hopes that you find this a useful and accessible resource when dealing with domestic violence patients.

Dr. Matthew K. Hoffman, Obstetrics & Gynecology
Chair, Medical Subcommittee
Domestic Violence Coordinating Council



Domestic Violence Coordinating Council

The Domestic Violence Coordinating Council is a State agency legislatively created in 1993 to improve Delaware’s response to domestic violence. The DVCC brings together domestic violence service providers and policy-level officials to identify and implement improvements in system response through legislation, education, training and policy development.

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Section I: Introduction

Domestic violence is a serious social problem that affects the health and well-being of millions of people each year. According to Amnesty International “violence against women is one of the most pervasive human rights abuses. It is also one of the most hidden.”¹ Though the true scope of domestic violence is nearly impossible to measure, various statistics can help define the issue. It is estimated that about 1.3 million women and 835,000 men experience domestic violence annually.² Domestic violence occurs in both heterosexual and same-sex relationships and can happen to intimate partners who are spouses, living together, dating or apart. In 2009, violent crimes by intimate partners (current or former spouse, boyfriend or girlfriend) accounted for 26% of non-fatal violent crimes against females and 5% against males.³

The purpose of this resource manual is to provide accessible information to Health Care Providers (HCP) in Delaware regarding the screening and treatment of patients for domestic violence. Effective screening and treatment can best occur if the HCP has an understanding of the complex dynamics of domestic violence. This manual provides important information regarding victim safety, power and control tactics and community resources.

This resource manual was developed by the Medical Subcommittee of the Domestic Violence Coordinating Council of Delaware. The committee membership includes health care providers, domestic violence advocates and affiliated professionals.

The Importance of Universal Screening for Domestic Violence

Domestic violence is a major public health problem, resulting in injuries and other short term and long term health consequences, including mental illness and complications of pregnancy. It is a chronic life-threatening condition that is treatable. HCPs need to recognize that persons who are victims of domestic violence will be patients in every medical facility. Neither victims nor batterers fit a distinct personality or profile and abuse affects people of all ages, ethnicities, and socioeconomic classes. Predicting which persons will be affected is difficult, which suggests that universal screening is more appropriate than targeting specific groups.

Exposure of children to domestic violence results in emotional, behavioral, and health problems. Children exposed to Intimate Partner Violence incur 20% higher health care costs than children who are not exposed.⁴

**Failure to screen for domestic violence may have serious consequences:**

- increased risk of chronic illness
- complications during pregnancy
- unnecessary testing
- misdiagnosis
- serious injury or death

In addition to enhancing our awareness of domestic violence, several things have been shown to increase the probability patients will disclose their abuse. First, HCPs have to ask about domestic violence. Only 19% of HCPs screen patients for domestic violence while 98% screen for tobacco usage. Secondly, screening for domestic violence needs to be a part of the normal routine of HCPs. Screening can be accomplished with a questionnaire filled out by the patient or a directed interview conducted by you or a staff member. Lastly, studies have shown that an abused person is more likely to disclose their abuse when asked in a private environment by a compassionate, nonjudgmental provider.

The Center for Disease Control and Prevention (CDC) has adopted the RADAR system, a training device to encourage providers to incorporate screening into practice. This is an acronym developed to assist in the important issues of screening for domestic violence.

- R** - Routinely screen every patient, make screening a part of every day practice from prenatal, postnatal, routine gynecological visits, and annual health screenings.
- A** - Ask questions directly, kindly and in a nonjudgmental manner.
- D** - Document findings in the patient's chart using the patient's own words with details and use body maps and photographs as necessary.
- A** - Assess the patient's safety and see if the patient has Domestic Violence Hotline numbers and other resources.
- R** - Review options of dealing with domestic violence with the patient and provide referrals.⁵



Screening for domestic violence should not be cumbersome. Long lists of questions may impede the process.

Members of the public take Health Care Provider's opinions seriously. When you screen your patients for domestic violence and make referrals to relevant resources, you communicate your concern about this issue, validate the victim's experience and provide an opportunity for the victim to seek help. You may be the only person providing domestic violence information to that victim.



Section II: Legal Mandate & Recommendations

Delaware Law does not require mandatory reporting of domestic violence

Neither Delaware Law nor the Health Insurance Portability Accountability Act (HIPAA) mandates reporting of a crime, occurrence, act or incident solely because that crime, occurrence, act or incident constitutes an act of domestic violence. However, certain injuries regardless of the relationship between parties must be reported (refer to page 9).

Why does Delaware Law not require mandatory reporting of domestic violence?

Victims should be free to make their own choices as to whether or not to report; as reporting may increase the level of violence. Mandatory reporting of domestic violence could actually discourage victims from seeking medical care or from confiding in their HCPs. Additionally, some batterers prevent their victims from seeking medical attention until the victim promises that he/she will not reveal the source of the injuries. As a result, more victims may suffer from untreated injuries.

In addition, a law that mandates reporting of all patients who present with domestic violence injuries invokes basic professional, ethical, and moral questions for health care providers whose tradition has recognized that trust is essential to the process of healing and effective treatment.

People who are injured as a result of domestic violence need medical attention, emotional support, and non-judgmental information about their options. Over time, the victim who receives that support from their physician and others will integrate it into their own thought processes and develop a plan that works for their unique circumstance. Escaping a violent relationship is a process that requires the resolution of complex issues such as housing, financial self-sufficiency, and protecting the children from abuse or abduction. Threats are often used by the perpetrator to establish and/or maintain control. In some situations, it may take the victim months or even years to resolve these complex issues. Mandatory reporting of injuries may cause the victim to flee prematurely, before the plan can be fully implemented and premature flight can increase the risk of serious injury and homicide.

Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the victim's consent.



When is Mandatory Reporting Required?

Mandatory reporting is required for the following:

- 1) Suspected child abuse – [16 Del. C. §903](#)
- 2) Suspected abuse of infirm adults – [31 Del. C. § 3910](#)
- 3) Elder Abuse [16 Del. C. § 1132](#)
- 4) All 2nd or 3rd degree burns over 5% of the total body surface or any significant respiratory tract burn – [16 Del. C. § 6614\(f\)](#)
- 5) All non-accidental poisoning – [24 Del. C. § 1762](#)
- 6) All stab wounds – [24 Del. C. § 1762](#)
- 7) All bullet wounds, gunshot wounds, powder burns, or other injury caused by the discharge of a gun, pistol, or other firearm – [24 Del. C. § 1762](#)

Domestic violence between dating partners who are both under 18 does not require a mandatory report unless the minor who committed the incident either:

- 1) Committed an act that would fall under any of the seven categories above.
- 2) Committed an act of sexual abuse or sexual assault against their underage partner or
- 3) While having the “care, custody or control” of the minor partner, the perpetrator either: mistreats, maltreats, exploits, tortures, emotionally abuses or physically injures the minor. “Care, custody or control” over a minor shall mean a person or persons in a position of trust, authority, supervision or control over a child.
[10 Del. C. § 901\(3\)](#)

Sexual abuse or sexual assault of a minor requires mandatory reporting. However, although mistreating, exploiting, torturing, emotionally abusing and/or physically injuring constitutes intimate partner abuse; the person who commits these acts must have care, custody or control over his/her partner in order for his/her acts to meet the definition of “abuse” for mandatory reporting purposes.

How to evaluate legal age of consent for sexual activity

18 years and older: Can consent to sexual contact with other adults. There is no mandatory reporting unless you suspect that perpetrator has access to child victims.

16 and 17-year-olds: Can consent to sexual contact with someone who is under 30 years of age. However, 16 and 17-year olds can NOT legally consent to sexual contact with anyone who is in a position of authority or trust. (For example: family member, babysitter, coach, teacher, doctor, clergy, etc.) If the



person is in a position of authority or trust, you **MUST** report. If the perpetrator has immediate access to the victim you report as soon as possible (e.g. perpetrator is with them, or lives in the household).

12-15 year-olds: Can **ONLY** consent to sexual contact with someone who is no more than 4 years older than the child. (For example, a 13 year-old can consent to have sexual contact with a 15 year-old. A 13 year old can not consent to have sexual contact with an 18 year old). However, 12-15 year olds can **NOT** legally consent to sexual contact with anyone who is in a position of authority or trust. If the person is in a position of authority or trust, you **MUST** report. If the perpetrator has immediate access to the victim, you report as soon as possible (for example: perpetrator is with them or lives in the household).

Under 12-years-old: Children under 12 years old can **NOT** legally consent to sexual contact. All of these cases **MUST** be reported. If the perpetrator has immediate access to the victim you must report immediately (for example: perpetrator is with them, or lives in the household).

Note: Verbal consent by the victim (e.g. saying “yes” to sexual activity) without satisfying the criteria above is still “without consent” and must be reported.

[11 Del. C § 761](#)

Vulnerable Adults Reporting Requirements

Numerous accounts of maltreatment led policy makers to pass a series of laws intended to protect elderly victims. The passage of the federal Older Americans Act of 1965 (OAA) and the creation of the Vulnerable Elder Rights Protection Program in 1992 were instrumental in promoting state laws to address the needs and concerns of the elderly.

The Vulnerable Elder Rights Protection Program legislation promoted advocacy efforts through ombudsmen offices; abuse, neglect and exploitation prevention programs; and legal assistance on behalf of older Americans. In the State of Delaware, there is **MANDATORY REPORTING** for health care professionals, long-term care facility personnel, and mental health professionals when they suspect abuse, neglect, or exploitation of an elder ([16 Del.C. § 1132](#)), or other vulnerable adult ([31 Del.C. § 3910](#)).

Mandatory Reporting Violations

Failure to report child abuse may result in a fine no more than \$10,000 for the first violation, and not to exceed \$50,000 for any subsequent violation. [16 Del. C. § 914](#)

Failure to report non-accidental poisonings, stab wounds, bullet, gunshot or powder burns (in adults) may result in a fine of no less than \$100 nor more than \$2500. Recklessly failing to report burns, as required above, to the Fire Marshal shall result in a fine of no more than \$100 or imprisonment of no more than 10 days or both.



Clinical Illustrations

These case illustrations provide examples of how health care providers can appropriately handle suspected domestic violence cases.

Case 1:

A patient presents at a physician's office seeking treatment for a laceration to the thigh. The account offered by the patient is that the laceration was self-inflicted when he accidentally cut himself while sharpening a lawnmower blade in his lap. The wound is large and jagged, but exhibits gunpowder stippling and does not appear to be a wound caused by a knife or lawnmower blade. When confronted with the powder burns, the patient states that ashes fell off a cigarette and denies there being a gunshot injury.

Appropriate Response: The physician explains to the patient that under Delaware law, she is required to report this type of injury to law enforcement. The physician contacts law enforcement authorities and reports that the victim is being treated for a possible gunshot wound. Additionally, the physician screens for domestic violence by asking relevant questions. Despite the patient's denial, the physician expresses concern, gives the patient a resource card and offers to allow the patient to confidentially call the Domestic Violence Hotline before leaving the office. All findings, inconsistencies and explanations are carefully documented.

Case 2:

A patient presents at your office with two black eyes and a contusion across the bridge of the nose. The patient explains that she opened the car door quickly and struck her nose causing the injuries. You notice bruising on the forearms and upper arms and fresh scrapes on the neck. Upon domestic violence screening, the patient reports rough sex and occasional pushing and shoving matches with her spouse. The patient does not acknowledge that there is any domestic violence and despite your inquiries, does not want to report the incident to law enforcement.

Appropriate Response: You explain to the patient that you are very concerned for her safety and that no one deserves to be physically assaulted. You explain that there are resources available to her and people that she can speak to confidentially about her situation. You offer to allow her to privately call the Domestic Violence Hotline from your office. You schedule a follow-up visit with the patient, document the visit and make a note to ask her about domestic violence at the next visit.



Insurance Coverage

Health Insurance Coverage

It is unlawful to refuse health insurance coverage for a patient because of injuries from or history of domestic violence. [18 Del.C. § 2304\(24\)\(a\)](#).

It is also illegal to refuse to cover any injury or problem because it is the result of domestic violence. [18 Del.C. § 2304\(24\)\(c\)](#).

Any violation of these laws should be reported to the Insurance Commissioner.

- **Delaware Insurance Commissioner's - Consumer Services Department** at 1-800-282-8611 (in Delaware only) or (302) 674-7310.

Affordable Care Act

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for patients by requiring health plans to cover preventive services and by eliminating cost sharing. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a co-payment, coinsurance or deductible for these services when they are delivered by a network provider.

New health plans will need to include these services, without cost sharing, for insurance policies with plan years beginning on or after August 1, 2012. The rules governing coverage of preventive services which allow plans to use reasonable medical management to help define the nature of the covered service apply to women's preventive services. Plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost-sharing for branded drugs if a generic version is available and is just as effective and safe for the patient to use.

The Affordable Care Act seeks to stop health problems before they start. The historic guidelines are based on science and existing literature and will help ensure that victims get the preventive health benefits they need. The U.S. Department of Health and Social Services (HHS) directed the independent Institute of Medicine (IOM) to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep women healthy. HHS' Health Resources and Services Administration used the IOM report issued, when developing



new guidelines. The IOM's report relied on independent physicians, nurses, scientists, and other experts to make determinations based on scientific evidence.

In the summer of 2010, the HHS released new insurance market rules under the Affordable Care Act requiring all new private health plans to cover several evidence-based preventive services like mammograms, colonoscopies, blood pressure checks, and childhood immunizations without charging a co-payment, deductible or coinsurance. The Affordable Care Act also made recommended preventive services free for people on Medicare.

The new guidelines build on that progress by making sure that women have access to a full range of recommended preventive services without cost sharing, including:

- Well-woman visits;
- Screening for gestational diabetes;
- Human papilloma virus (HPV) DNA testing for women 30 years and older;
- Sexually-transmitted infection counseling;
- Human immunodeficiency virus (HIV) screening and counseling;
- FDA-approved contraception methods and contraceptive counseling;
- Breastfeeding support, supplies, and counseling; and
- **Domestic violence screening and counseling.**

This legislation is a significant step to ensuring that our health care system and providers will be partners in identifying and helping victims of domestic violence.

Existing Recommendations for Screening and Counseling

The clinical value of screening for domestic violence has been widely acknowledged. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires policies and procedure for identifying, treating, and referring victims of abuse in emergency departments and ambulatory settings. Professional organizations for healthcare providers, such as the American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American Association of Colleges of Nursing (AACN) have published guidelines that encourage screening as a way to identify domestic violence and abuse early and to positively impact health outcomes for patients.



Section III: Screening for Domestic Violence

A. Approaches for Working with Domestic Violence Victims

The approach of the HCP in addressing domestic violence is critically important. **The HCP should make an opening supportive statement such as “Because abuse and violence are so common, I’ve begun to ask about it routinely.”** Even if the victim does not respond at the time, the fact that a HCP is concerned and believes that domestic violence is a possibility will make an impression. By adopting the approaches listed below, the HCP is likely to be successful in addressing and perhaps preventing domestic violence.

Patient interviews must be conducted in private

- An HCP should never assume that it is safe to ask questions concerning domestic violence in front of any other party.
- Questioning a victim in front of his/her abuser may actually increase that victim’s risk of danger.
- A victim needs to be made to feel safe and secure in order to openly and honestly discuss his or her situation.

Be an advocate for your patients

- When asked in a supportive, safe environment, most patients will answer truthfully.
- Suspecting domestic violence but not following through with referrals is a missed opportunity to offer support and resources which could possibly save a life.
- Allow victims to talk about their ambivalence toward their abuser. Recognize that no one gives up a relationship without a struggle.
- Recognize that some victims of abuse leave and return to their partners several times. **This is not a failure; safely leaving an abusive partner is a process.**



**Do No Harm
("Primum non nocere")**

This maxim applies at two levels:

- It is important that we conduct ourselves in a way that encourages the abused person to use the health care system. We may be the first or last source of help a victim turns to.
- Missing the signs of domestic violence, just like overlooking a diagnosis of pneumonia, diabetes or peptic ulcer, is a lost chance to assist the patient in dealing with a health risk.

Support and respect the patient

- It is particularly important that our patients receive our support – we may be the only ones in their corner.
- Contrary to the usual medical model of “diagnose and prescribe”, providers intervention is a success if the victim of domestic violence is talking about the violence and beginning to explore his/her options.
- Accept that each victim must find solutions he/she can live with. Some people find divorce unacceptable; others simply cannot move to a new community or to a shelter where no one shares their culture.

Refer to Resources

- It is not necessary for the HCP to know every domestic violence resource available. Refer to the Domestic Violence Hotline and allow those trained professionals to further assist the patient.
- Offer patients the option of privately calling the Domestic Violence Hotline before he/she leaves your office. Some victims of domestic violence will not have the privacy or means to make the phone call outside of the medical facility.
- Do not assume that a patient already knows about available resources. You may be the first person to talk to that patient about domestic violence.

The method used in screening for domestic violence may contribute more to the success of this endeavor than the content of our questions. The following list is a helpful overall approach to assessing victims of domestic violence:



Checklist

- Address the presenting complaint. Complete the history and physical, including screening questions about domestic violence.
- Inform the patient of available options, initiate necessary treatment and make appropriate referrals.
- Document the visit, recommendations and response.

Things to Avoid

- **Avoid** assigning any blame to the victim. Ask questions in a nonjudgmental manner.
- **Avoid** the terms “*battered*”, “*abused*”, or “*victim of domestic violence*”, as the victims often do not see themselves in that way.

Sample Questions

Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it.

- Do you ever feel afraid of your partner?
- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner?
- Has your partner ever forced you to have sex when you didn’t want to?

B. Symptoms Associated with Domestic Violence

Although a victim of domestic violence can present with no symptoms, domestic violence has been linked to a variety of symptoms and physical findings. Sometimes victims do not realize their symptoms are linked to their abuse and frequently do not offer the etiology of their physical injuries.

Physical Symptoms

Chronic pain, psychogenic pain, or exaggerated pain response

- Headaches
- Atypical chest pain
- Abdominal pain/gastrointestinal problems



Symptoms of depression

- Sleep and appetite disturbances
- Fatigue
- Difficulty with concentrating

Genito-urinary problems

- STDs
- Frequent U.T.I.s
- Dyspareunia
- Pelvic pain
- Miscarriage/vaginal bleeding
- Premature labor

Vague neurological symptoms

- Dizziness

Paresthesias

Physical Injuries

An abusive injury can take any form. The following should arouse more than the usual suspicion.

- Injuries to the head, neck, chest, breasts, abdomen, and genitals
- Injuries during pregnancy
- Placental abruption
- Multiple sites of injury
- Injuries in various stages of healing
- Sexual assault
- Any bite mark
- Repeated or chronic injuries
- Injuries that are inconsistent with the history
- Injuries consistent with strangulation

Behavioral Indicators

Patient Behavior

- Patient is evasive, frightened or anxious
- Patient is reluctant to leave the medical facility
- Concern is out of proportion to the problem
- Doctor shopping
- Frequent visits, or frequent missed/cancelled visits
- Suddenly leaving a provider's office or hospital
- Explanation is inconsistent with normal physiology or inconsistent with injuries
- Patient is reluctant to answer questions in presence of others
- Prescription, alcohol, or other substance abuse problem
- Suicidal ideations, suicide attempts, or overdoses
- Noncompliance/non-adherence with medications



Perpetrator Behavior

- Perpetrator answers questions for patient
- Perpetrator may appear overly attentive.
- Perpetrator is reluctant to leave when asked to do so
- Perpetrator minimizes injuries
- Perpetrator demeans or attributes blame to the patient
- Perpetrator has a substance abuse problem
- Appointments cancelled by someone other than patient

Safety Issues for Domestic Violence Victims

Safety issues include the well being of the patient, children, other loved ones, and pets and can be assessed in a short period of time.

Immediate concerns

- Is your partner here now?
- Does he/she have access to a gun or other weapon?
- Do you feel safe leaving with your partner?
- Do you want to call the police? If no, do you want to report this?

If a patient answers in the affirmative to any of the above questions or if you still suspect abuse, the HCP should refer the victim to resources. The domestic violence hotlines are your greatest resource and ally. The hotlines are staffed by trained professionals who are equipped and available to assist victims of domestic violence 24/7: **New Castle County – Domestic Violence (302) 762-6110, Rape Crisis (302) 761-9100; Northern Kent County – Domestic Violence (302) 768-3886; Kent & Sussex County – Domestic Violence (302) 422-8058, Rape Crisis (302) 262-9800, Bi-Lingual Hotline (302) 745-9874.** HCPs should offer the patient the option of calling the Domestic Violence Hotline in a private and confidential setting prior to leaving the health care facility. The hotline worker will confidentially speak to the individual about their particular situation and provide information, options, safety planning, and resources.

The hotline worker can explain the following:

Victims planning to leave have a number of options

- Shelter services
- Advocacy services
- Choice to notify law enforcement and begin Criminal Proceedings (See Appendix F on page 59).
- File Civil Proceedings in Family Court (Protection from Abuse Order). See Appendix F.

It is important to remember that except in circumstances that require mandatory reporting (see page 9). It is a breach of confidentiality to call law enforcement without the victim's consent.



**Safety
Planning**

- Tips for maximizing safety before/during/after leaving an abusive relationship
- Information about the Cycle of Violence
- Legal options and remedies available to the victim

Resources

- Civil Protection from Abuse Orders (PFA)/Criminal No Contact Orders
- Court based advocates
- Counseling programs for victims and children
- Batterers Intervention programs for perpetrators
- Reporting to police
- Assistance with transportation
- Legal assistance
- Temporary housing for pets

Services are available at no cost to the victim.

C. Overcoming Perceived Barriers

Health Care Providers have demonstrated a commitment to screening for domestic violence. Understanding the perceived barriers is the first step towards more effective screening.

**Time
Constraints**

- A HCP can screen for domestic violence in a few minutes.
- Domestic Violence effects health in many ways thereby resulting in increased visits to HCPs. Identification of a domestic violence victim, along with appropriate referrals to resources, increases the effectiveness of the HCP response and thereby can decrease the number of necessary visits to the HCP.

**Providers fear
they will
offend their
patient**

- HCPs routinely query patients on highly personal and sensitive topics such as sexual practices, dietary indiscretions, cigarette smoking and substance abuse. Asking a patient about an abusive relationship is no more difficult than asking patients about sex, drugs and bowel habits.
- When questions are asked in a caring manner with a stated reason (for example, “Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it”), patients are not offended and will frequently say they are glad someone finally asked them about the violence.



Some HCPs have not seen domestic violence in their practice and believe it does not effect their particular population

- Patients with more education or economic resources are not immune to abuse. They may have more sophisticated alibis for their injuries.
- Regardless of socioeconomic class all patients should be screened for abuse.

Some HCPs don't know what to do if domestic violence is identified

- It is not necessary for the HCP to know every domestic violence resource available. Refer to the Domestic Violence Hotline and allow those trained professionals to further assist the patient. This resource is available 24/7.
- Offer patients the option of privately calling the Domestic Violence Hotline before he/she leaves your office. Some victims of domestic violence will not have the privacy or means to make the phone call outside of the medical facility.
- If the patient does not wish to call the Domestic Violence Hotline, let him/her know that there are resources available to him/her whenever he/she is ready. Offer to give the patient a resource card or the Domestic Violence Hotline.

D. Documentation

Well-documented medical records are essential when working with victims of domestic violence. They provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of a legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible.

Tips for a well documented medical record

- Describe the details of the history and physical exam precisely and accurately, including the name of the perpetrator of the violence, a description of the assault or controlling behavior, and an objective description of the injuries or findings.
- Avoid any subjective interpretation of events or data.
- Chief complaint and description of the abusive event should use the patient's own words whenever possible rather than the physician's assessment. "My husband hit me with a bat" is preferable to "Patient has been abused". Use quotations when documenting the victim's description of abuse.

**The medical record should include**

- Photographs may be helpful for acute injuries.
- Written consent for taking the photographs should be obtained whenever possible. Any photographs taken should be labeled with the patient's name, medical record number and date, and secured with the rest of the chart.

- The patient's complete medical history.
- Any relevant social history.
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing. (see Appendix C)
- Document inconsistencies with normal physiology or inconsistent with injuries.
- Results of all pertinent laboratory and other diagnostic procedures.
- Color photographs and imaging studies, if applicable.
- If the police are called, the name of the investigating officer and any actions taken.

If photo documentation is applicable and permissible, the HCP should ask for the Forensic Nurse for assistance when possible. **Consent for photos should be signed whenever possible.** (16 Del.C. § 1232(a), 16 Del.C. § 1230(2), 16 Del. C. §1230(4)) (See Appendix D, pages 56-57, for a sample consent form in English and Spanish). Name of the patient and the date should be indicated on the photo. Try to include the victim's face in each of the photos, for example, if the injury is on the hand, have the victim hold their hand up next to their face. The photo is given to the police if the assault is reported; otherwise it should be placed in a separate file in a secure location. HCPs must inform themselves as to applicable laws regarding maintaining photos as part of the medical record. A list of the photos taken (photo-log) with a very brief description is helpful for identification later. The police may do all the photographing if they are called and available. HCPs should be prepared that when taking photographs, both the photographs and the HCP may be subpoenaed for the purpose of legal actions.

Please refer to the Strangulation and Sexual Assault sections for information on documentation of those specific crimes.



E. Resources and Hotline Numbers

The Domestic Violence Hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and refer to available resources. Services are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711).

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers	
<u>New Castle County</u>	
Domestic Violence	302-762-6110
Rape Crisis	302-761-9100
<u>Northern Kent County</u>	
Domestic Violence	302-678-3886
<u>Kent & Sussex County</u>	
Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874



Section IV: Domestic Violence

A. Definition and Scope of Problem

Domestic Violence is any abusive act between family members, ex-spouses, intimate cohabitants, former intimate cohabitants, dating couples and former dating couples in which one party seeks to gain/maintain power and control over the other partner. Couples or former couples can be of the same or opposite sex. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.⁶

Two Categories of Domestic Violence

Domestic Violence consists of “Intimate Partner Violence,” which includes current and former spouses, current and former dating couples with or without a child in common and dating couples. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering.

Domestic Violence also includes “Non-Intimate Partner Violence,” which is violence between individuals who are not intimate partners, but have a familial relationship, such as, mother/adult son, or brother/sister.

Domestic violence not only affects those who are abused, but also has a substantial effect on family members, friends, co-workers, other witnesses, and the community at large. Children, who grow up witnessing domestic violence, are among those seriously affected by this crime. Frequent exposure to violence in the home not only predisposes children to numerous social and physical problems, but also teaches them that violence is a normal way of life - therefore, increasing their risk of becoming society's next generation of victims and abusers.⁷



B. Dynamics of Domestic Violence

Why does Domestic Violence Occur?

Violent and abusive behavior in relationships results from a complex mix of learned behavior, cultural values and historical precedent

- Witnessing violence between one’s parents or caretakers is the strongest risk factor of transmitting violent behavior from one generation to the next.⁸
- Media portrayals of relationships are often violent and highly sexualized. Conflicts between partners are characterized by verbal and physical aggression. The level of generalized violence in the media including movies, television shows and video games contributes to a culture that accepts violence as a means of expression.
- It is important to note that domestic violence is not caused by the victims’ behavior, the use of alcohol or drugs, stress or mental illness.
- Those who abuse make a choice to engage in abusive behavior because they can – and because it works to get what they want.

Characteristics of Victims and Perpetrators

Who Are the Victims?

Victims of domestic violence can belong to any socioeconomic, ethnic or racial group.

- Old and young, female and male, gay and straight.
- Abuse may affect their ability to get or keep a job, maintain contact with friends and family, and develop connections within their communities.
- Domestic violence may have long term effects on a person’s physical and emotional well being.



Who Are the Perpetrators?

Perpetrators also belong to any socioeconomic, ethnic or racial group.

- Old and young, female and male, gay and straight.
- They may have been abused as children or witnessed a parent or other family member being abused.
- Perpetrators often exhibit a pattern of jealous and controlling behavior that isolates, threatens, and frightens their partner.
- Perpetrators may see their partner as central to their existence.
- Perpetrators may be violent only within the abusive relationship.

Power and Control Techniques

Physical violence is the most typical form of abuse associated with domestic violence. However, victims suffer many types of abuse at the hands of their partners. Sexual coercion and assault are frequently part of the dynamics of a violent relationship. In addition, the power and control tactics described below reflect the common experiences of many victims of relationship violence. These tactics are used by perpetrators of domestic violence to maintain power and control over their partners.

This chart (See Figure 1 – Power & Control Wheel) shows the kinds of behavior perpetrators use to gain and maintain control over their victim. **Domestic violence abuse is never an accident.** It is an intentional act used to gain control over the other person. Physical abuse is only one part of a whole series of behaviors an abuser uses against his/her victim. **Violence is never an isolated behavior.** There are other forms of abuse, which are shown in the Power and Control Wheel.



Figure 1: POWER AND CONTROL WHEEL⁹

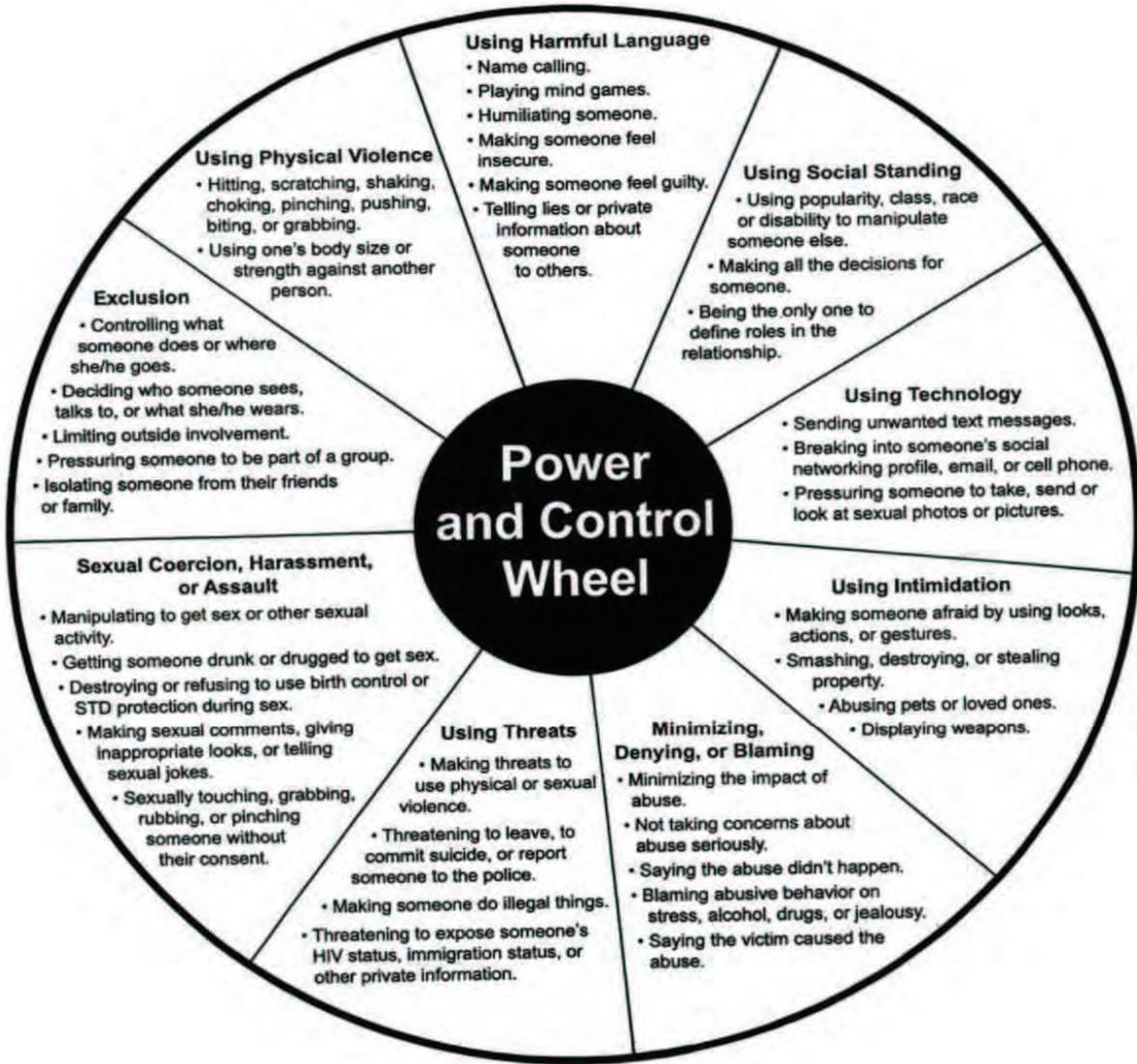
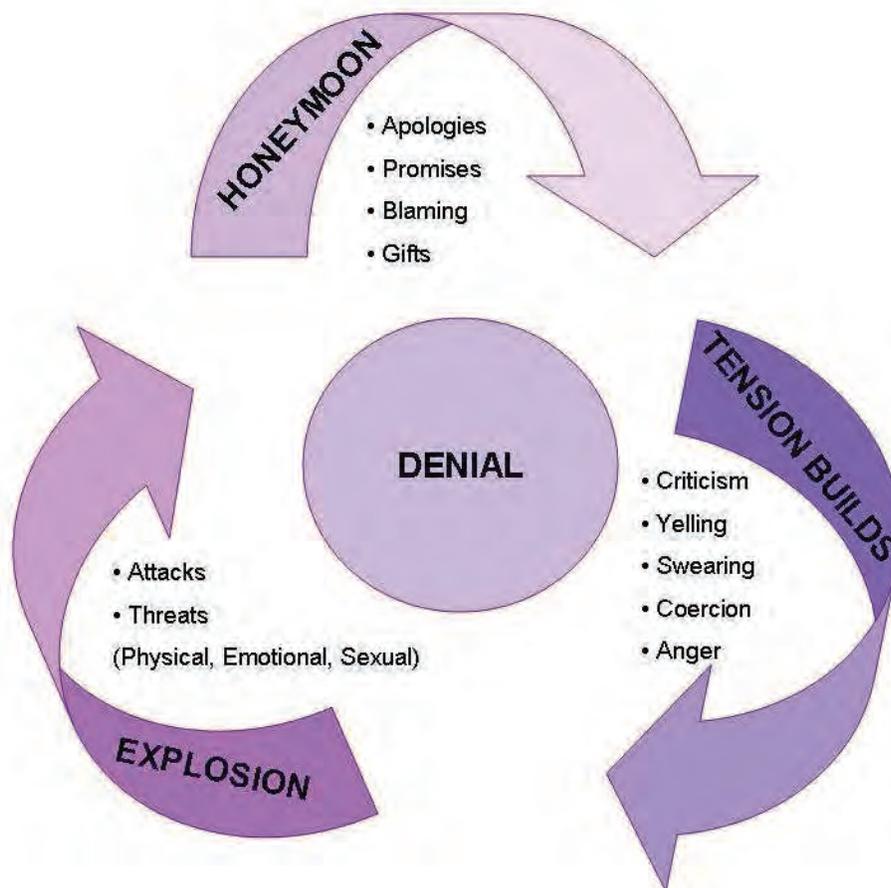




Figure 2: The Cycle of Violence

The Cycle of Violence was first described by Lenore Walker in her 1979 work *The Battered Woman*. The Cycle of Violence has been described as having three stages: the tension building stage; the violent episode; and the honeymoon stage (calm/ making up). **Not all abusive relationships follow this cyclical pattern.**

The Cycle of Violence





Why Victims Stay in Abusive Relationships

Why don't they just leave?

Leaving an abusive relationship does not guarantee an end to the abuse; rather, the abuse often escalates at the time of separation. The most dangerous time for a victim can be when he/she attempts to leave or end the abusive relationship.

Many domestic violence murder-suicides occur when the victim tries to end the relationship.

Increased threats to children and other family members.

The fact that many victims do leave or seek help is truly remarkable in light of the many barriers they face.

Barriers faced when leaving an abusive relationship include:

- increased danger to victim and children
- fear of retaliation by the abuser
- lack of awareness of services
- lack of financial resources
- fear of losing custody of the children
- fear of not being believed
- religious, family and societal pressures
- shame
- denial of seriousness of abuse
- belief that the abuser will change/hope for a continued relationship
- lack of support network
- cultural and ethnic/racial barriers



Cultural Issues

Impact of cultural issues on victims of domestic violence

Cultural differences can add further barriers to victims attempting to end abusive relationships.

- Courts, social service agencies, law enforcement and advocacy programs often lack fulltime interpreters to assist non-English speaking victims in filing complaints or accessing services.
- Victims from diverse cultures must work with programs and services that are unfamiliar with their language or customs and may seem unresponsive to their needs.
- Undocumented immigrant victims may be afraid to involve law enforcement out of fear that contact with the criminal justice system could result in deportation for the victim and/or their family.

Victims should be informed that reporting to the police or requesting a PFA from the courts will not subject him/her to deportation or removal proceedings.

HCP's should be prepared to complete an assessment in the patient's native language and not depend on a potential perpetrator.

Effects on Children

It is essential for HCPs to understand the effects that domestic violence has on children. This information, when utilized to educate a victim, is often a catalyst for a victim to obtain resources or leave an abusive relationship. Information should be delivered in a nonjudgmental and caring manner not as a means of scaring an individual into seeking help. Communicate to the victim that he/she is not to blame and that there is help available to the victim and his/her children.

Children of all ages can be deeply affected by domestic violence

- Children who witness domestic violence are more likely to be in an abusive relationship when they grow up – whether as the abuser or the abused; and often experience anxiety, depression, eating and sleeping disorders and developmental delays and behavior problems.
- Delaware law recognizes that a child can be a witness to an act of domestic violence by sound as well as sight, acknowledging that a child may have only heard the violent act from another room, but nonetheless be a witness who is emotionally impacted by it. [11 Del. C. 8 §1102\(a\)\(4\)](#)



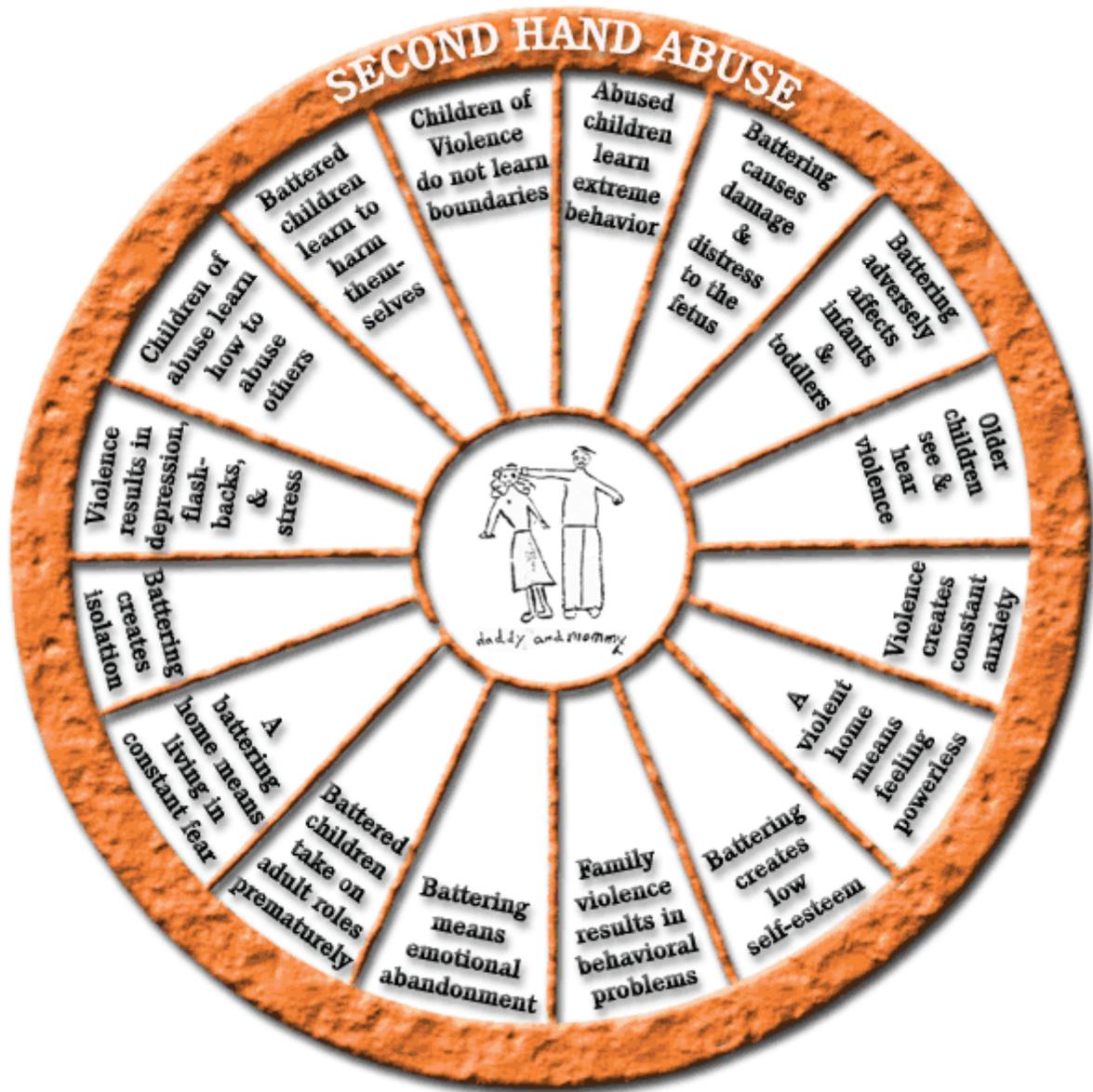
Infants	May not develop the appropriate attachments to their caretakers who are crucial to their development and may suffer “failure to thrive”.
Preschool children	May regress developmentally and suffer sleep disturbances including nightmares.
School age children	Develop behavioral problems including: depression, anxiety, violence toward peers and difficulty with authority. In some cases the anxiety level can be so high children are afraid to attend school for fear of what will happen to the abused parent or younger siblings when they are not home.
Adolescents	<p>Have increased risk for repeating abusive behavior patterns in their dating relationships.</p> <p>They are also at increased risk for alcohol and drug abuse, criminal behavior and eventual entry into the criminal justice system.</p> <p>Adolescents are at risk of academic failure, school drop-out, delinquency, and substance abuse. Some investigators have suggested that a history of family violence or abuse is the most significant difference between delinquent and non delinquent youth.¹⁰</p>

Children who witness domestic violence may have the following symptoms

- eating, sleeping disorders;
- mood related disorders such as depression, emotional neediness;
- over compliance, clinginess, withdrawal;
- aggressive acting out; destructive rages;
- detachment, avoidance, a fantasy family;
- somatic complaints;
- finger biting, restlessness, shaking, stuttering;
- school problems, and
- suicidal ideations.



Figure 3: Second Hand Abuse Wheel¹¹





C. Resources and Hotline Numbers

The Domestic Violence Hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and will refer to available resources. Services are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711).

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers	
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<u>Kent & Sussex County</u>	
Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874

Available Resource/Services Include:

- Safety Planning
- Court Assistance
- Police Assistance
- Group/Individual Counseling
- Transitional Housing
- Shelters
- Case Management
- Legal Representation
- Financial Assistance
- Career Training & Assistance



Section V: Sexual Assault

Sexual Assault Nurse Examiner

Sexual Assault Nurse Examiners (SANEs) are specially trained to provide comprehensive care for victims of sexual assault. SANEs provide physical care and can be emotionally supportive while objectively collecting evidence and documenting observations. It is possible that they may testify in court on their findings as well. The SANEs are part of the statewide multi-disciplinary Sexual Assault Response Team (SART). SART coordinates the efforts of law enforcement officers, rape crisis advocates, the Department of Justice, Attorney General's office, medical professionals and community referral agencies. The team was created to ensure that victims of sexual assault are not revictimized by the medical and legal systems. SART strives to provide a safe and secure environment for victims of sexual assault, to reduce the victim's emotional trauma, and to promote support for the recovery journey.

NOT ALL HOSPITALS HAVE A SANE PROGRAM. If you have a patient who is thinking about reporting a sexual assault to the police, you should instruct them to go to the nearest hospital that has a SANE/Forensic Program to have a Sexual Assault Evidence Collection Kit (ECK) completed. The patient should be instructed to, if possible, not wash his/her body, change his/her clothes, eat, smoke, brush his/her teeth, or otherwise clean up. By doing so, physical evidence may be lost or damaged. Evidence can be collected up to 72 hours after the assault; however, the longer it takes to collect the evidence, the chances of finding usable evidence diminishes.

Delaware SANE Programs

Beebe Medical Center (302) 645-3311

Christiana Care Health Systems (302) 733-4799

Bayhealth Medical Center (302) 744-7122

Nanticoke Memorial Hospital (302) 629-6611x2555

Nemours/Alfred I. duPont Hospital for Children (302) 651-4000

*Note: Below material was reprinted, with permission, from the National Sexual Violence Resource Center's publication entitled *Assessing Patients For Sexual Assault: A Guide For Health Care Providers*. This guide is available by visiting www.nsvrc.org*

A. Definition and Scope of Problem

Sexual assault is any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Activities falling under the definition of sexual assault: forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape.



In the United States, 1 in 6 women and 1 in 33 men reported experiencing an attempted or completed rape at some time in their lives. These numbers underestimate the problem. Many cases are not reported because victims are afraid to tell the police, friends, or family about the abuse because victims also think that their stories of abuse will not be believed and that the police cannot help them. Victims may be ashamed or embarrassed and may also keep quiet because they have been threatened with further harm if they tell anyone.

B. Dynamics of Sexual Assault

Sexual assault can impact victim's health in many ways. Some ways are serious and can lead to long-term health problems. These include chronic pain, headaches, stomach problems, and sexually transmitted diseases.

Sexual assault has an emotional impact as well. Victims often are fearful and anxious. They may replay the attack over and over in their minds. They may have problems with trust and be wary of becoming involved with others. The anger and stress that victims feel may lead to eating disorders and depression. Some even think about or attempt suicide.

Sexual assault is also linked to negative health behaviors. For example, victims are more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual activity.

Assessing patients

While studies have shown that most female patients want to be asked about their experiences with sexual violence by their health care providers, few medical professionals screen any patients, female or male, for such trauma. This may be due to a lack of training, time, or comfort on the part of the health care provider. However, doctors' offices can be safe, confidential places to address sexual violence in which survivors can feel comfortable disclosing and confident in receiving the care and services they need. Many prominent health organizations recommend that providers screen their patients for violence, including the American Medical Association, the World Health Organization, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Nurses Association.

Although most of the current research and recommendations regarding screening patients for sexual violence focuses on women, some programs have begun screening both male and female patients with promising results. The Veterans Health Administration recently implemented a universal screening program for male and female veterans that will provide free care for any patient experiencing conditions resulting from military sexual trauma. The program found that both men and women who screened positive for military sexual trauma were more likely to seek out mental health care after being screened than those who screened negative.



Screening patients is only one step in the process. A full assessment requires that health care providers also develop plans and protocols for what to do when a patient discloses incidents of sexual victimization.

Developing assessment protocols

Health care providers should develop protocols that ensure consistent, effective practices for providing care to patients that experience sexual violence. One promising tool that can aid providers in these efforts is the **SAVE** method, which was developed by the Florida Council Against Sexual Violence (2003).

- **S**creen all of your patients for sexual violence
- **A**sk direct questions in a non-judgmental way
- **V**alidate your patient's response
- **E**valuate, educate and make referrals

Protocols should stipulate that patients be assessed regularly (e.g., annually), as this will give patients multiple chances to disclose victimization and allow time for the patient to develop a trusting relationship with the provider.

Medical providers are encouraged to consider their professional ethics and organizational policies in order to form protocols which safeguard the privacy of victims and survivors in every aspect of their practice, including documentation and information sharing with other providers. The decision to document disclosures of sexual violence, in particular, should be carefully considered. Trainings and consultations for medical providers on this topic are available through sexual violence prevention and services centers and state coalitions against sexual violence. The Sexual Assault Network (SAND) of Delaware is a resource for training and consultations on this topic. SAND's contact information is (302)761-9800 or on-line at: www.contactlifeline.org.

How to discuss sexual violence

Normalize the Topic

- I need to ask you some personal questions. Asking these questions can help me care for you better.
- I ask all of my patients this question because it is important for me to know what has gone on in their lives.

Provide context to your questions

- We know that sexual violence is common in the lives of many women, men, girls, and boys.

Connect sexual violence to the patient's physical health and well being

- Sexual violence can affect a person's health.

**Ask about sexual experiences that were unwanted or made the person feel uncomfortable**

- Have you ever been touched sexually against your will or without your consent?
- Have you ever been forced or pressured to have sex?
- Do you and your partner ever disagree about sexual things? Like what? How do you resolve these conflicts?
- Do you feel that you have control over your sexual relationships and will be listened to if you say “no” to having sex?

Health care providers should AVOID

- Asking patients about their victimization when other people are present
- Only asking patients who “seem” like victims about their experiences
- Using the term “rape,” as some survivors may not label their experience as rape
- Using formal, technical, or medical jargon
- Only asking about specific types of violence or recent violence
- Expressing value judgments

If a patient discloses sexual violence, clearly describe what your reporting requirements are and what information might be included in their medical records so that they can make informed decisions about what they disclose. Demonstrate through body language that you are listening to your patient’s response.

Respond with validating messages that allow the patient to feel heard and believed.

- “I’m really sorry that happened to you.”
- “That sounds like it was a terrifying experience.”
- “I’m really glad you had the courage to tell me.”
- “I want you to know it wasn’t your fault.”

When documenting responses in a medical chart, use the patient’s own words.**Evaluate the patient’s needs**

- Is the patient in current danger?
- If the assault happened recently, does the patient want a forensic exam to be performed?
- If the assault happened within the past 120 hours, and the patient is female, does the patient want emergency contraception?
- Does the patient need or want prophylaxes for HIV or other sexually transmitted infections?



- Does the patient have acute injuries that need medical attention?
- Do special accommodations need to be made to make the patient feel safe?
- Does the patient need to schedule a follow-up appointment?
- Does the patient wish to speak with a sexual assault advocate?

Collaborating with community partners

Collaborating with local sexual violence experts is key to successful assessment and support for victims. Each program in such collaborations can provide the others with referrals, professional in-services, trainings, public education/outreach, and specialized services. For example, state sexual violence coalitions and community-based sexual violence prevention and services centers are often able to provide publications that can help health care providers educate patients about sexual violence. Collaborations can ensure that sexual violence assessments are effective while strengthening the community effort to identify and respond to victims of sexual violence.

Selected assessment instruments

The CDC has compiled a list of instruments that can be used to screen for sexual violence entitled [*Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Health care Settings*](#). Instruments outlined in this document include:

- **Abuse Assessment Screen (AAS)** – Five items that assess physical, sexual, and emotional abuse.
- **Screening Tools-Sexual Assault** – Five items that assess sexual assault and knowledge of risk reduction strategies.
- **Sexual and Physical Abuse History Questionnaire** – Six of the items in this scale assess sexual abuse.
- **Two-Question Screening Tool** – One of two items assesses sexual violence.
- **Universal Violence Prevention Screening Protocol** – Five items that assess recent physical, sexual, and emotional abuse.
- **Victimization Assessment Tool** – Five items that assess a variety of kinds of violence, including sexual violence.¹²



C. Resources and Hotline Numbers

The sexual assault hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and will refer to available resources. Services are available to victims who are hearing impaired or who do not speak English.

Crime victim compensation programs are often able to provide financial support to victims of violence for medical expenses and other costs that arise as a result of the crime. More information is available through the [Delaware Victims' Compensation Assistance Program](#). The phone number is: (302) 255-1770. If the patient does not disclose sexual violence, offer education and prevention information and provide follow-up at the next visit.

ContactLifeline – Rape Crisis

1-302-761-9100 or 1-800-262-9800

www.contactlifeline.org

Survivors of Abuse in Recovery

New Castle County
(302) 655-9049

Kent & Sussex Counties
(302) 422-3811

www.survivorsofabuse.org



Rape, Abuse, and Incest National Network (RAINN)

1-800-656-HOPE

Refers a victim to local rape crisis centers.

Directory of Sexual Assault Centers in the United States

1-877-739-3895

www.nsvrc.org

Additional Resources:

- *Screening Patients for Sexual Violence*, a CD tutorial program
<http://www.pcar.org/long-term-health-effects-sexual-assault-and-rape>
- *Put down the chart, pick up the questions: A guide for working with survivors of sexual violence*,
<http://www.pcar.org/sites/default/files/file/healthcare/put-down-the-chart.pdf>
- National Sexual Violence Resource Center, www.nsvrc.org
- Centers for Disease Control and Prevention, www.cdc.gov
- Sexual Assault Network of Delaware (SAND), www.contactlifeline.org
- Delaware Health Social Services (DHSS), www.dhss.delaware.gov
- Department of Services for Children, Youth, and Their Families (DSCYF),
www.kids.delaware.gov



Section VI: Teen Dating Violence

A. Definition and Scope of the Problem

Few of us are used to asking teenagers about their dating practices. Yet there is growing evidence that teens are abused by their boyfriends and girlfriends at rates comparable to those of long term adult relationships. Statistics show that one in three teenagers has experienced violence in a dating relationship.¹³

In dating violence, one partner tries to maintain power and control over the other through abuse. Dating violence crosses all racial, economic and social lines and can be physical, sexual, economic or psychological. Early intervention is thought to be essential to helping young people develop healthy, respectful relationships with their partners.

What are the consequences of Teen Dating Violence?

As teens develop emotionally, they are heavily influenced by their relationship experiences. Healthy relationship behaviors can have a positive effect on a teen’s emotional development. Unhealthy, abusive or violent relationships can cause both short term and long term negative effects or consequences. Victims of teen dating violence are more likely to do poorly in school and report binge drinking, suicide attempts and physical fighting. Victims may also carry the patterns of violence into future relationships.

Special issues for Teen Victims

- Teens are likely to see possessiveness and jealousy as signs of affection.
- Victims may be confused by conflicting feelings of love, anger and fear.
- Teens are reluctant to turn to adults for help.

B. Dynamics of Teen Dating Violence

Teens are often even more reluctant than adult victims to get help for domestic violence. There is an increased fear among teen victims that they are partly to blame and that adults will judge them. In addition to the standard domestic violence warning signs (discussed on page 17), teen warning signs may include the following: (Figure 3 – Teen Power and Control Wheel page 42)¹⁴

Additional warning signs that a teen may be being abused

- Their boyfriend/girlfriend calls them names or puts them down in front of others.
- Their boyfriend/girlfriend acts extremely jealous when they talk to friends of the opposite sex, even when it is completely innocent.



- The teen often cancels plans at the last minute, for reasons that sound untrue.
- The teen frequently apologizes for their boyfriend/girlfriend.
- The teen’s boyfriend/girlfriend is constantly checking up on them, calling or texting, and demanding to know where they have been.
- The teen is worried about upsetting their boyfriend/girlfriend.
- The teen has recently given up things that used to be important to them, such as spending time with friends or other activities, and is becoming more and more isolated.
- The teen’s weight, appearance or grades have changed dramatically.
- The teen has injuries they can’t explain, or the explanations they give don’t add up.

The best way to gather information about the above warning signs is to ask questions. Explain to the teen patient that you are asking routine questions. Remain non-judgmental and supportive. Advise the teen that it is not their fault and they do not deserve to be treated that way.

C. Resources and Hotline Numbers

The Domestic Violence Hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and will refer to available resources. Services are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711). Additionally, teens can receive age appropriate information and services via www.loveisrespect.org or www.safeandrespectful.org, which also offers a live on-line chat for teens to utilize and obtain resources.

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers		
<u>New Castle County</u>		
Domestic Violence		302-762-6110
Rape Crisis		302-761-9100
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<u>Kent & Sussex County</u>		
Domestic Violence		302-422-8058
Rape Crisis		302-262-9800
Bi-lingual Hotline		302-745-9874



Figure 3:

TEEN POWER AND CONTROL WHEEL



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NATIONAL CENTER
on Domestic and Sexual Violence
training • consulting • advocacy
4412 Shoal Creek Blvd. • Austin, Texas 78738
512.437.9020 (phone and fax) • www.ndsv.org



Section VII: Child Abuse

A. Definition and Scope of the Problem

In 2009, 870,382 children and adolescents were confirmed victims of child abuse in the United States and 2,242 confirmed victims of child abuse in Delaware.¹⁵ Despite these numbers, the estimated number of actual victims is much higher. Child abuse remains an underreported and undetected problem for several reasons, including individual and community variations in what is considered “abuse,” inadequate knowledge and training among professionals in the recognition of abusive injuries, unwillingness to report suspected abuse and professional bias.

If you suspect a child is being abused or neglected, **you must report**

According to the Delaware code

- "Abuse" or "abused child" means that a person, causes or inflicts sexual abuse on a child; or a person who has care, custody or control of a child, and causes or inflicts: physical injury through unjustified force; emotional abuse; torture; exploitation; or maltreatment or mistreatment. [10 Del. C. § 901\(1\)](#)
- "Neglect" or "Neglected Child" is defined in Delaware as: A person who has care, custody and control of a child and the financial means to care for that child fails to provide necessary care with regard to: food, clothing, shelter, education, health, medical or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being; or that person chronically and severely abuses alcohol or a controlled substance, is not active in treatment for such abuse, and the abuse threatens the child's ability to receive care necessary for that child's safety and general well-being, or that person fails to provide necessary supervision appropriate for a child when the child is unable to care for that child's own basic needs or safety, after considering such factors as the child's age, mental ability, physical condition, the length of the caretaker's absence, and the context of the child's environment. [10 Del. C. § 901\(18\)](#)



B. Dynamics of Child Abuse

The first step in helping abused or neglected children is to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring in a family, but a closer examination of the situation may be warranted if more than one of these occur often or a few of these are presented at once. **If you suspect abuse, you must report.** Reporting suspected abuse may help protect the child and get help for the family.

Partial list of suspicious findings

Physical Abuse

- Bruises of trunk, genitals, or ears
- Bruises in the pattern of a foreign instrument (belt, cord)
- Immersion burns or cigarette burns
- Ligation marks or bite marks
- Rib fractures or metaphyseal fractures
- Any fracture in a child under 3 years
- Retinal hemorrhages
- Injury inconsistent with history

Physical Neglect-most prevalent form of child maltreatment

- Malnutrition
- Noncompliant with medical care
- Delay in seeking treatment
- Inadequate hygiene
- Inadequate supervision

Sexual Abuse

- Genital injury
- Sexually transmitted disease
- Pregnancy

Failure to Thrive

- Substantial lack of growth
- Reduced response to stimulation
- Poor eye contact
- Lack of cuddliness or response to affection
- Indifference to the presence of others
- Expressionless face or lack of affect or social smile
- Extremely weak cry
- Decreased body activity, arms close to body in a semi-fetal position
- Infant cannot be comforted



C. Resources and Hotline Numbers

An immediate oral report shall be made by any and all persons who have reason to suspect child abuse or neglect to the 24-Hour Division of Family Services (DFS) Child Abuse Report Line. The person who spoke to or observed the child directly should make the report and that person should also provide the names of any other person in the agency, organization or entity who has knowledge of the alleged abuse or neglect.

**24-Hour Division of Family Services (DFS)
Child Abuse Report Line**

1-800-292-9582



Section VIII: Abuse of Vulnerable Adults

Note: Vulnerable adults include elders and adults with mental or physical disabilities.

A. Definition and Scope of Problem

Abuse, neglect and exploitation of elders and other vulnerable adults have no boundaries and cross all racial, social class, gender and geographic lines. Spiraling rates of elder abuse are reported by both practitioners and researchers. In a national study of Adult Protective Services (APS), there were 253,421 reports of abuse of adults age 60 or older or 832.6 reports for every 100,000 people over the age of 60¹⁶. The National Elder Abuse Incidence Study (National Center on Elder Abuse, 1998) found that more than 500,000 persons aged 60 or older were victims of domestic abuse and that an estimated 84% of incidents are not reported to authorities, denying victims the protection and support they need. These elders are subject to injury and to premature death¹⁷, often from caregivers and family members. Each year, 5,000,000 vulnerable adults who are not elders are abused, neglected or exploited¹⁸. Abuse of vulnerable adults is estimated to cost Americans tens of billions of dollars annually in health care, social services, investigative and legal costs, and lost income and assets.

Abuse of vulnerable adults includes several types of violence that occur among those ages 60 and older and adult individuals who have a mental or physical disability. The violence usually occurs at the hands of a caregiver or a person the individual trusts.

If you suspect abuse of an adult with mental or physical disabilities, you must report. [31 Del C. § 3910](#). If you suspect abuse of an elder adult, you must report. [16 Del. C. § 1132](#).

Six types of elder abuse

- **Physical** - occurs when a vulnerable adult is injured as a result of hitting, kicking, pushing, slapping, burning, or other show of force.
- **Sexual** - involves forcing a vulnerable adult to take part in a sexual act when the individual does not or cannot consent.
- **Emotional** - refers to behaviors that harm a vulnerable adult's self-worth or emotional well being. Examples include name calling, scaring, embarrassing, destroying property, or not letting the individual see friends and family.
- **Neglect** - is the failure to meet a vulnerable adult's basic needs. These needs include food, housing, clothing, and medical care.
- **Abandonment** - happens when a caregiver leaves a vulnerable adult alone and no longer provides care for him or her.
- **Financial** - is illegally misusing a vulnerable adult's money, property, or assets.



Warning signs of elder abuse

- Frequent arguments or tension between the caregiver and the vulnerable adult.
- Changes in personality or behavior in the vulnerable adult.

Clusters of the following physical and behavioral signs are indicators that the vulnerable adult may be abused.

B. Dynamics of Elder Abuse

Physical abuse

- Unexplained signs of injury such as bruises, welts, or scars, especially if they appear symmetrically on two sides of the body
- Broken bones, sprains, or dislocations
- Report of drug overdose or apparent failure to take medication regularly (a prescription has more remaining than it should)
- Broken eyeglasses or frames
- Signs of being restrained, such as rope marks on wrists
- Caregiver’s refusal to allow you to see the individual alone

Emotional abuse

- Threatening, belittling, or controlling caregiver behavior that you witness
- Behavior from the vulnerable adult that mimics dementia, such as rocking, sucking or mumbling to oneself

Sexual abuse

- Bruises around breasts or genitals
- Unexplained venereal disease or genital infections
- Unexplained vaginal or anal bleeding
- Torn, stained or bloody underclothing

Neglect by caregivers or self-neglect

- Unusual weight loss, malnutrition, dehydration
- Untreated physical problems, such as bed sores
- Unsanitary living conditions: dirt, bugs, soiled bedding and clothes
- Being left dirty or unbathed
- Unsuitable clothing or covering for the weather
- Unsafe living conditions (no heat or running water; faulty electrical wiring, other fire hazards)
- Desertion of the vulnerable adult at a public place



Financial exploitation

- Significant withdrawals from the vulnerable adult’s accounts
- Sudden changes in the vulnerable adult’s financial condition
- Items or cash missing from the vulnerable adult’s household
- Suspicious changes in wills, power of attorney, titles, and policies
- Addition of names to the vulnerable adult’s signature card
- Unpaid bills or lack of medical care, although the individual has enough money to pay for them
- Financial activity the vulnerable adult couldn’t have done, such as an ATM withdrawal when the account holder is bedridden
- Unnecessary services, goods or subscriptions

C. Resources and Hotline Numbers

To report abuse or neglect of a vulnerable adult, call 911 and Adult Protective Services.

Emergency Services

911

Adult Protective Services

1-800-223-9074

The domestic violence hotline numbers are also an important resource and may be used in cases where the vulnerable adult is being abused within the context of an intimate partner relationship. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and will refer to available resources. Services are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711).

Calls will be kept confidential and the complainant can remain anonymous if desired.



Section X: Strangulation

A. Definition and Scope of Problem

Segen's Medical dictionary describes strangulation as "The act of suffocating a person by constricting the trachea or upper airways". Strangulation occurs frequently in domestic violence situations. The act of strangulation symbolizes an abuser's power and control over the victim. The victim is overwhelmed by the abuser; he/she vigorously struggles for air and is at the mercy of the abuser. A traumatic experience of strangulation or the threat of it may instill so much fear that the victim can get trapped in a pattern of control by the abuser and made vulnerable to further abuse.

Strangulation can be a recurring form of violence in abused women's lives. In a study of 62 abused women who came to a shelter or a violence prevention center, 68% had a history of strangulation, and on an average, each woman had been strangled 5.3 times in their intimate relationships.¹⁹

Strangulation is a significant risk factor for attempted or completed homicide of women by their male intimates. In a study of 57 women who were killed by a male partner during 1995-1996 in Chicago, 53% of the victims had experienced strangulation in the preceding year and 18% of the victims had been killed by strangulation.²⁰ In another study of women victims it was found that 45% of the attempted homicide victims and 43% of the homicide victims had been strangled in the past year by their male partner, as compared to 10% of the victims who were abused but were neither a homicide or an attempted homicide victim. Screening patients and referring them for services could quite possibly save their lives.²¹

B. Dynamics of Strangulation

Strangulation can have substantial physical, neurological and psychological health effects. The higher the number of strangulation attempts experienced, the higher the number of adverse health conditions experienced by victims.

Screening for Strangulation

HCPs have found that victims of strangulation very rarely report the crime to HCPs without being specifically asked about it. When victims are specifically asked about strangulation, they will often confirm the offense. It is therefore essential for HCPs to ask about strangulation and to appreciate the fact that patients may not know the appropriate terminology. **Victims almost never use the word "Strangulation". They are more likely to report strangulation as: Choking, choking out, or getting beat up.**



Below are some of the effects of strangulation:

Physical

- Dizziness
- Nausea
- Sore throat
- Voice changes
- Throat and neck injuries
- Breathing problems
- Swallowing problems
- Ringing in the ears
- Vision Change
- Miscarriage
- Loss of consciousness

Neurological

- Eyelid droop
- Facial droop
- Left or right side weakness
- Loss of sensation
- Loss of memory
- Paralysis

Psychological

- Post Traumatic Stress Disorder (PTSD)
- Depression
- Suicidal ideation
- Insomnia

Strangulation often leaves no marks or any other external evidence on the skin. In a study of police records of 300 strangulation cases, victims did not have any visible injury in 50% of the cases and in 35% of the cases the injuries were too minor for the police to photograph.²² The difficulty in detecting strangulation is a challenge for law enforcement and medical professionals, which helps make it a particularly useful means of intimidation and harm for an abuser.

Symptoms in severe cases of strangulation may include

- Patient may appear disoriented or confused
- Drooling or coughing
- Fingernail or ligature marks on the neck
- Bruising on the neck
- The presence of petechial hemorrhages in the eyes, face, roof of mouth, and neck area
- Loss of consciousness
- Difficulty/pain with swallowing



- Involuntary urination/defecation
- Loss of voice or voice change
- Persistent throat pain
- Breathing difficulties

Please note that in most cases of strangulation, none of these symptoms will be present. This does not make the act less serious or dangerous.

C. Documentation

Due to the severity and lethality risks associated with strangulation, good documentation is essential. See Appendix A & B for an example of the strangulation documentation tools.

The medical record should include

- The patient's complete medical history.
- Any relevant social history.
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing. (see Appendix C)
- Document inconsistencies with normal physiology or inconsistent with injuries.
- Results of all pertinent laboratory and other diagnostic procedures.
- Color photographs and imaging studies, if applicable.
- If the police are called, the name of the investigating officer and any actions taken.

Documenting strangulation

- Examine the scalp, eyelids, conjunctiva, chin, jaw, ears, throat, interior and exterior of mouth, shoulders, fingernails, clothing and chest
- Record injuries and findings on diagrams
- Documents the method of strangulation (one hand, two hands, ligature)
- Document the approach of the attack (from front, from back)
- Note the estimated duration of strangulation
- Note the description of the event using the victim's words whenever possible
- Photograph injuries when appropriate



D. Resources and Hotline Numbers

The Domestic Violence Hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and will refer to available resources. Services are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711).

Refer to Resources

- It is not necessary for the HCP to know every domestic violence resource available. Refer to the Domestic Violence Hotline and allow those trained professionals to further assist the patient.
- Offer patients the option of privately calling the Domestic Violence Hotline before he/she leaves your office. Some victims of domestic violence will not have the privacy or means to make the phone call outside of the medical facility.
- Do not assume that a patient already knows about available resources. You may be the first person to talk to that patient about domestic violence.

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers	
<u>New Castle County</u>	
Domestic Violence	302-762-6110
Rape Crisis	302-761-9100
<u>Northern Kent County</u>	
Domestic Violence	302-678-3886
<u>Kent & Sussex County</u>	
Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874



Appendix B: Strangulation Documentation Tool - 2



Beebe Medical Center

STRANGULATION DOCUMENTATION TOOL

Checklist:

- Assess for emergent situation
- Photograph patient demonstrating (but not physically touching)
- Examine scalp, eyelids, conjunctiva, chin, jaw, throat, shoulders, fingernails, clothing, and chest

Page 2

Record injuries and findings on diagrams; erythema, abrasions, bruise (detail shape), contusions, induration, separations, fractures, bites, burns, stains and foreign materials on the body.

Diagram A 	Diagram B 	Diagram C
Diagram D 	Diagram E 	Diagram F

LEGEND: Types of findings Findings No Findings

- | | | | | |
|------------------|------------------------|--|----------------------|-----------------------|
| AB: Abrasion | DS: Dry Secretion | IN: Induration | PE: Petechiae | TD: Tooth Decay |
| BC: Bite | EC: Erythema (redness) | IW: Incised Wound | PS: Potential Saliva | TF: Tooth Fractured |
| BU: Burn | ER: Erythema (redness) | LA: Laceration | SI: Suction Injuries | TM: Tooth Missing |
| CS: Control Swab | FB: Foreign Body | MS: Moist Secretion | SW: Swelling | V/S: Vegetation/Solid |
| DE: Debris | FI: Fiber/Hair | OF: Other Foreign Materials (describe) | TE: Tenderness | WL: Wood's Lamp |
| DF: Deformity | FT: Frenulum Torn | OI: Other injuries (describe) | TA: Tooth Avulsed | |

Locator #	Type	Description	Locator #	Type	Description

Signature/Title: _____ Print Name: _____ Date: _____

08/25/09 dmb



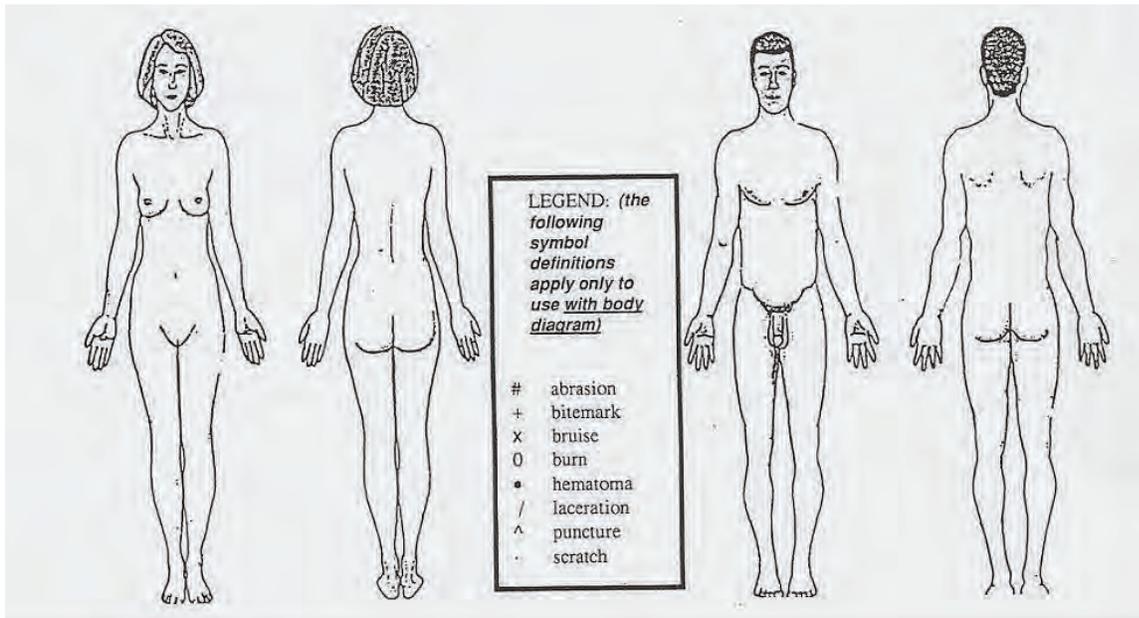
Appendix C: Intimate Partner Violence Documentation Tool

Date _____ Patient ID# _____

Patient Name _____ Pregnant? Yes ___ No ___

DOCUMENT YOUR FINDINGS

Patient Report (Use patient's own words)-Patient description of the assault (struck with fists or object, kicked, thrown, etc):



Comments:

Print Name: _____ Date: _____



Appendix D: Consent to Photograph - English

In the event a photograph is taken, be sure to complete this form and include the patient's signature.

The undersigned hereby authorizes _____
(Name of Agency)

and the attending physician to photograph or permit other persons in the employ of this facility to photograph _____
(Name of Patient)

while under the care of this facility, and agrees that the photographs be stored in the patients medical record, sealed in a separate envelope, in the event they may be needed later for evidence. These records will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs:

Date _____ Patient's Signature _____

Witness _____

Patient's Parent or Legal Guardian

Street Address

City State Zip



Appendix D: Consent to Photograph - Spanish

La persona firmando aqui autoriza por este medio _____

(Name of Agency)

y el médico de asistencia para fotografiar o para permitir a otras personas en el empleo de esta facilidad a la fotografía _____(nombre de paciente)

durante el cuidado de esta facilidad, y conviene que las fotografías estén almacenadas adentro del informe médico de los pacientes, sellado en un sobre separado, en caso de que necesiten evidencia más adelante.

Estos expedientes serán enviados a la policía o al abogado del estado de Delaware solamente cuando el infrascrito da el permiso para enviar los formes médicos.

El infrascrito no autoriza ningun otro uso de estas fotografías:

Firma del paciente _____

Fecha _____

Testigo _____

Padre o guardian legal del paciente _____

Direccion de calle _____

Cuidad _____

Estado _____

Código postal _____



Appendix E: Screening for Domestic Violence

Because anyone can be a victim of domestic violence, every patient should be screened.

- Explain to the patient the purpose of asking questions about domestic violence. This can be achieved by universalizing the problem in order to provide a less threatening context.
- State that questions are asked routinely to all patients because of the prevalence of domestic violence and its' potential harm to victims.

The patient discloses domestic violence.

- Remain non-judgmental and supportive.
- Validate your patient's experience. You may be the first or only person that he/she tells about the abuse.
- Inform the victim that there are resources available to help him/her.
- Offer to allow the victim to privately call the Domestic Violence Hotline from the medical facility prior to leaving.
- When safe to do so, give the patient a domestic violence resource card and/or the Domestic Violence Hotline number.
- When appropriate, schedule a follow-up visit and make a note to talk to the patient about domestic violence again.
- Respect the patient's choices.

You believe that the patient is denying abuse or the patient refuses help.

- Respect your patient's choice of whether to disclose abuse and/or to seek help.
 - Attempting to leave an abusive relationship is a dangerous time for victims.
 - There are many reasons and risks that may influence a victim's decision to not leave an abusive relationship immediately.
- It often takes several visits to the HCP before the victim discloses abuse.
- Let the patient know that you are available in the future if he/she should choose to seek assistance for domestic violence.
- Document your concerns and treatment in the patient's medical chart and when applicable make a notation to follow-up at future visits.
- Provide information and pamphlets in the waiting rooms, examination rooms and bathrooms.

Domestic Violence/Rape Crisis **24-Hour Hotline Numbers**

New Castle County

Domestic Violence	302-762-6110
Rape Crisis	302-761-9100

Northern Kent County

Domestic Violence	302-768-3886
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Kent & Sussex County

Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874



Appendix F: Legal Remedies for Domestic Violence Victims

	Protection From Abuse (PFA) Order	Criminal No-Contact Order
<p>Civil vs. Criminal</p> <p>Note: Having one of these in place does not preclude the victim from getting the other. The victim may have both a PFA and a criminal no-contact order.</p>	<p>This is a Civil remedy. In a civil case the victim brings the action against the abuser. The victim is asking the court to protect him/her from the abuser. The victim is not asking the court to send that person to jail for committing a crime. There can be criminal sanctions against the abuser if he/she violates the order.</p>	<p>A criminal no-contact order is often generated when the abuser is charged with a crime. In this case, it is the state that has brought the case against the abuser. The abuser is ordered to stay away from the victim as a condition of the offender's bail. Additionally, if the offender is sentenced for this crime, the no contact order may become part of the offender's sentence.</p>
<p>How to obtain</p>	<p>The victim can file for a PFA by filing in the Family Court in his/her county. There are advocates available at the Court to assist the victim.</p>	<p>This process is initiated by filing a report with law enforcement.</p>
<p>What does it do?</p>	<p>Depending on the circumstances a PFA can order the abuser to do all or some of the following:</p> <ul style="list-style-type: none"> • Stay away and/or stop contacting the victim • Stop threatening/abusing the victim (or his or her minor children) • Pay child and/or spousal support • Pay other expenses • Surrender any and all firearms • Attend counseling • Not destroy, sell or conceal joint property <p>A commissioner or judge may also grant:</p> <ul style="list-style-type: none"> • Exclusive use of the home and/or certain possessions (like a vehicle) • Temporary custody/visitation of children 	<p>In a criminal no contact order, the abuser is precluded from having any contact or communication with the victim.</p>
<p>How long does it last?</p>	<p>Most long-term orders are issued after a court hearing for up to a year. However, if it is necessary to prevent further acts of Domestic Violence an order may be issued for 2 years and where there is aggravating circumstances a permanent order can be issued.</p>	<p>The no contact order will be in place as long as the charges are still pending against the offender. If the offender is sentenced on the charges and the no contact order is made a part of the offender's sentence, the no contact order will be in place as long as the offender is still serving the sentence, whether that is incarceration or parole/probation.</p>
<p>Is there a fee?</p>	<p>No.</p>	<p>No.</p>
<p>For Additional Information</p>	<p>Court Information: Victims' Advocacy Centers New Castle County: 302-255-0420 Kent County: 302-672-1075 Sussex County: 302-856-5843</p>	<p>Attorney General's Office: Victim Witness Services Unit/Case Notification New Castle County: 302-577-8500 Kent County: 302-739-4211 Sussex County: 302-856-5353</p>



Appendix G: Domestic Violence Assessment Guide

Assessment Guide cards can be ordered from [Futures Without Violence](#).

Assess all Patients for Domestic Violence:

- * Talk to the patient alone in a safe, private environment
- * Ask simple, direct questions such as:

- **Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely.**
- **Are you in a relationship with a person who physically hurts or threatens you?**
- **Did someone cause these injuries? Who?**

The best way to find out about domestic violence is to ask directly.

However, be aware of:

- History suggesting domestic violence: traumatic injury or sexual assault; suicide attempt, overdose; physical symptoms related to stress; vague complaints; problems or injuries during pregnancy; history inconsistent with injury; delay in seeking care or repeat visits.
- Behavioral clues: evasive, reluctance to speak in front of partner; overly protective or controlling partner.
- Physical clues: any physical injuries; unexplained multiple or old injuries.

Take a Domestic Violence History:

- Past history of domestic violence, sexual assault
- History of abuse to any children

Send Important Messages to Patient (avoid victim blaming):

- You are not alone
- You are not to blame
- There is help available
- You do not deserve to be treated this way

Assess Safety:

- Are you afraid to go home?
- Have there been threats of homicide or suicide?
- Are there weapons present?
- Can you stay with family or friends?
- Do you need access to a shelter?
- Do you want police intervention?



Make Referrals:

- Involve social worker if available
- Provide list of shelters, resources, and hotline numbers (see below)
- Schedule follow-up appointment

Document Findings:

- Use the patient’s own words regarding injury and abuse
- Legibly document all injuries; use a body map
- Take photographs of injuries (after receiving consent), or enlist the services of a Sexual Assault Nurse Examiner (SANE).

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers	
<u>New Castle County</u>	
Domestic Violence	302-762-6110
Rape Crisis	302-761-9100
<u>Northern Kent County</u>	
Domestic Violence	302-678-3886
<u>Kent & Sussex County</u>	
Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874



Appendix H: Quick Reference Summary

Affordable Care Act:

Health Insurance reform legislation that helps make prevention affordable and accessible for patients by requiring health plans to cover preventive services and by eliminating cost sharing. Health plans must include screening and counseling for domestic violence without cost sharing for insurance policies with plan years beginning on or after August 1, 2012. Additional information is available beginning on page 12.

Child Abuse:

Child abuse occurs when a person causes or inflicts sexual abuse on a child; or a person who has care, custody, or control of the child and causes or inflicts: physical injury through unjustified force; emotional abuse; torture; exploitation; or maltreatment or mistreatment. [10 Del. C. § 901\(1\)](#). According to Delaware law, if you suspect a child is being abused or neglected, you must report. Additional information is available beginning on page 43.

Cycle of Violence:

The Cycle of Violence, first described by Lenore Walker in 1979, describes a cyclical pattern that is found to be common in many abusive relationships. The cycle is characterized by three stages: the tension building stage, the violent episode, and the honeymoon stage. Not all abusive relationships follow this pattern. Additional information is available beginning on page 27.

Documentation:

Documentation is essential when working with victims of domestic violence. Proper documentation may provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of any resulting legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Whenever possible, HCPs should quote verbatim the victim's explanation of injuries within the medical record. Consent must be obtained prior to any photo documentation. Additional information is available beginning on page 20.

Domestic Violence:

Domestic Violence is any abusive act between family members, husband and wife, ex-husband and wife, intimate cohabitants, former intimate cohabitants, dating couples and former dating couples. Couples or former couples can be of the same or opposite sex. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten,



blame, hurt, injure, or wound someone. Although a victim of domestic violence can present with no symptoms, domestic violence has been linked to a variety of symptoms and physical findings. Additional information is available beginning on page 23.

Insurance Coverage:

It is illegal to refuse health insurance coverage for a patient because their injuries result from domestic violence or a history thereof. Additionally, it is illegal to refuse to cover any injury or problem because it is a result of domestic violence. Additional information is available on page 12.

Intimate Partner Violence (IPV):

Intimate Partner Violence is a type of domestic violence that involves physical, sexual, economic or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV can vary in both frequency and severity. Additional information is available beginning on page 23.

Mandatory Reporting:

Domestic abuse is **not** mandatorily reportable. Below are the instances in which abuse requires a mandatory report.

- 1) Suspected child abuse – 16 Del. C. §903
- 2) Suspected abuse of infirm adults – 31 Del. C. § 3910
- 3) Suspected elder abuse – 16 Del. C. § 1132
- 4) All 2nd or 3rd degree burns over 5% of the total body surface or any significant respiratory tract burn – 16 Del. C. § 6614 (f)
- 5) All non-accidental poisoning – 24 Del. C. §1762
- 6) All stab wounds – 24. Del. C. § 1762
- 7) All bullet wounds, gunshot wounds, powder burns, or other injury caused by the discharge of a gun, pistol, or other firearm – 24 Del. C. §1762

Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the victim's consent. More information is available beginning on page 8.

Referral:

All patients who acknowledge domestic violence should be referred. Many patients who deny domestic violence will accept a referral number. There are a wide variety of confidential resources and services available to victims of IPV at no cost to the victim. The Domestic Violence Hotlines are available 24/7 and staffed by professionals who are trained to assist victims with safety planning and making appropriate referrals. Services



are available to victims who do not speak English or who are hearing impaired (for Delaware Relay Services, dial 711).

Domestic Violence/Rape Crisis 24-Hour Hotline Numbers	
<u>New Castle County</u>	
Domestic Violence	302-762-6110
Rape Crisis	302-761-9100
<u>Northern Kent County</u>	
Domestic Violence	302-678-3886
<u>Kent & Sussex County</u>	
Domestic Violence	302-422-8058
Rape Crisis	302-262-9800
Bi-lingual Hotline	302-745-9874

Screening for Domestic Violence:

To be effective, HCPs should be screening for domestic violence routinely. The majority of victims of domestic violence present to healthcare practitioners with non-physical injuries. The prevalence of domestic violence among patients with anxiety, substance abuse and chronic pain disorders is very high. The form of the questions should be adapted to the situation but should be asked in a nonjudgmental fashion and followed by statements of positive support. To introduce the subject of abuse you may wish to use a framing statement such as “Because conflict and violence are so common in our daily lives, I’ve begun asking about it routinely.” The HCP may choose to use either a direct or indirect question depending upon the situation and degree of rapport with the patient and risk profile. “Did someone hit you?” is an example of a direct question while “Are you having problems?” takes an indirect approach. Interview the patient alone since asking about domestic violence in front of the perpetrator could endanger the victim. Additional information is available beginning on page 14.

Sexual Assault:

Sexual Assault is a type of domestic violence that includes any type of sexual contact or behavior that occurs without explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape. Sexual assault can impact health in many ways including long-term health problems, emotional effects, and



a higher likelihood of negative health behaviors (for example: Smoking, drugs, risky sexual behavior). Additional information is available beginning on page 33.

Strangulation:

Strangulation is the act of suffocating a person by constricting the trachea or upper airways. Strangulation occurs with startling frequency in domestic violence situations and can have substantial physical, neurological and psychological health effects. Victims generally refer to strangulation as: choking, choking out, or getting beat up. Strangulation often leaves no marks or any other external evidence on the skin. Additional information is available beginning on page 49.

Support:

All victims of domestic violence need to hear that violence is illegal and should not be tolerated. Victims should be provided with the domestic violence hotline numbers and informed that services are available in the community to assist them with housing, legal counsel, social services and civil protection orders. Above all, do not be judgmental. The fact that many victims do leave or seek help is truly remarkable in light of the many barriers they face. Additional information is available beginning on page 14.

Teen Dating Violence:

Teen Dating Violence is a type of domestic violence that refers to physical, sexual, or psychological violence within the context of a dating relationship between teens. There is growing evidence that teens are abused by their significant others at rates comparable to those of long term adult relationships. Victims of teen dating violence are more likely to do poorly in school, and report binge drinking, suicide attempts and physical fighting. Additional information is available beginning on page 40.

Vulnerable Adult Abuse:

This is a type of domestic violence perpetrated against individuals 60 and older and/or adults with a mental or physical disability. Abuse of a vulnerable adult may include physical, sexual, emotional, neglect, abandonment and/or financial abuse. To report the abuse of an elder or adult with mental or physical disabilities should report the incident to **Adult Protective Services at 1-800-223-9074**. Additional information is available beginning on page 46.



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If you are in danger, please call 911.

Domestic Violence/Rape Crisis 24 - Hour Hotline Numbers

New Castle County

Domestic Violence	302-762-6110
Rape Crisis	302-761-9100

Northern Kent

Domestic Violence	302-678-3886
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Kent & Sussex

Domestic Violence	302-422-8058
Rape Crisis	800-262-9800
Bi-lingual Hotline	302-745-9874

DVCC Main Office

Phone: 302-255-0405
Fax: 302-255-2236

DVCC Kent & Sussex County Office

Phone: 302-424-7238
Fax: 302-424-5311

Information Available

www.dvcc.delaware.gov

24-Hour Hotline Numbers
State Domestic Violence Policy
Dynamics of DV
Legislation
Publications
DV Resources
Related Links

Domestic Violence Coordinating Council

www.dvcc.delaware.gov