

2021 Domestic Violence Resource Manual

For Healthcare Professionals



Provided by Delaware's

Domestic Violence Coordinating Council

www.dvcc.delaware.gov

MESSAGE FROM THE CHAIR

This manual is an update to the DVCC Resource Manual for Healthcare Professionals of 2011. At the time, providers were advised of changes in domestic violence care pertinent to the Affordable Care Act. Currently, the crisis of our time is the COVID-19 pandemic, which has revealed weaknesses and inequities in our system, created challenges in providing care, and provided opportunities for improvement going forward.

Healthcare providers, like all human beings, are subject to limitations imposed by time, the systems in which they practice, and the tendency to be comfortable within their own area of expertise but very uncomfortable outside of it. The committee has endeavored to make this manual available either physically or electronically at the point of care to help any provider with screening and responding to a disclosure. Mandatory reporting requirements are provided so that the provider is equipped with the knowledge of how to respond in a way that preserves the patient's autonomy and safety. It bears repeating that the patient is the expert on the violence and an unmandated and undesired report to police or other authorities can put the patient in danger.

In this manual, related topics to domestic violence are also discussed, not to present an exhaustive treatment of those subjects, but because of overlapping circumstances. It may, for instance not be clear if a patient is suffering from intimate partner violence, is witness to child or elder abuse in their household, or is subject to human trafficking. Even if a precise diagnosis is not made at the time of the encounter, the same concepts apply to provide a safe space and to offer resources. Sections and pages can stand alone and as such much information is repeated in different ways and in different locations. A conscious effort was made to utilize inclusive language and trauma-informed practice.

The committee acknowledges the contributions of Megan Bittinger, DVS (YWCA Delaware Sexual Assault Response Center); Linda Brittingham, ACM-SW, CCM, CCMHC, BCD, LCSW, NCC (Christiana Care Health System); Geetanjali Chatterjee, NP (Christiana Care- Primary Care at Home Program); Patricia Curtin, MD, FAC, CMD (Christiana Hospital, Wilmington Hospital and Swank Memory Care Center); Delaware Sexual Assault Nurse Examiners: Dawn Culp (Bayhealth), Kathy Hudson (Nanticoke Hospital), Dana "Nikki" Morris, RN, SANE-P (Bebbee Healthcare), Anita Symonds (Christiana Hospital); Julie Devlin, Esq. (Division of Services for Aging and Adults with Physical Disabilities); Kristen Dricken, BS, RN (Children and Families First of Delaware); Rev. Karla Fleshman, LCSW (Transitions Delaware); Deputy Attorney General Jonathan Harting, Esq. (Department of Justice); Annamarie McDermott, MSW, ACM-SW (Saint Francis Hospital); Nancy McGee (ContactLifeline, Inc.); Rosalie Morales, MS (Office of the Child Advocate); Erin Ridout, MSW (Delaware Coalition Against Domestic Violence); DVCC Interns: Ashley Wilkerson and Lauren Cuevas; but most of all Dayna Belfiore, LMSW (DVCC), without whom this manual would never have been completed.

Margaret R. Chou, MD
Chair, Medical Committee
Domestic Violence Coordinating Council

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24-HOUR DOMESTIC VIOLENCE HOTLINES



(302) 762-6110 : New Castle

(302) 678-3886 : Sussex

(302) 244-8058 : Kent

(302) 745-9873 : Bi-lingual

**ADDITIONAL RESOURCES CAN BE FOUND IN
THE BACK OF THIS MANUAL**

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PLEASE NOTE: The information provided in this manual is designed to provide helpful information on the subjects discussed. Nothing contained in this manual should be construed as medical or legal advice.

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CHAPTER I: INTRODUCTION

The presence of domestic violence (DV) is a serious social determinant of health that affects the well-being of millions of people each year. It occurs across boundaries of race, class, sexual orientation, and gender identity, and may have significant, and often chronic, health consequences including, but not limited to, cardiovascular, gastrointestinal, reproductive, musculoskeletal, and nervous system conditions. Additionally, patients impacted by domestic violence may experience depression, sleep disturbances, post-traumatic stress disorder (PTSD), and are at higher risk for engaging in health risk behaviors, such as smoking, substance use, and HIV-risk behaviors (unsafe sexual practices).

The number of people in the United States impacted by domestic violence is far-reaching. According to the Centers for Disease Control and Prevention (CDC), 1 in 3 women experience intimate partner violence (IPV), most for the first time before age 25, and 1 in 7 men experience severe physical IPV. Domestic violence also impacts children, as it is estimated that 1 in 4 children have witnessed violence in the past year and 2 in 5 teenagers have been victims of assault, bullying, or teen dating violence. Within the LGBTQIA+ community, 61% of bisexual women and 37% of bisexual men experience rape, physical violence, and/or stalking by an intimate partner in their lifetime, while 44% of lesbian women and 26% of gay men experience rape, physical violence, and/or stalking by an intimate partner in their lifetime. 34.6% transgender individuals report physical abuse by a partner at some point in their lives and 64% report experiencing sexual assault. In the State of Delaware, between July 1, 2018 and June 30 2019, there were 23,210 combined criminal and non-criminal domestic violence incidents reported. Of the 12,868 criminal incidents reported, 13.2% resulted in physical injury to the victim.

1 in 3
women experience
intimate partner
violence, most before
age 25



1 in 7
men experience severe
physical abuse by an
intimate partner



34.6%
of transgender
individuals report
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abuse in their lifetime

Domestic violence is a public health problem. As healthcare providers, we may not think our patients are impacted by domestic violence, however; given its prevalence, healthcare providers in all fields will undoubtedly encounter patients affected by it. The State of Delaware's Domestic Violence Coordinating Council Medical Committee strives to ameliorate domestic violence and its effects in Delaware, by educating healthcare providers about best practice approaches. This manual provides important information regarding patient safety, power and control tactics used in a domestic violence relationship, and domestic violence community resources.

Members of the public trust healthcare providers and take our opinions seriously. Thus, we are in an optimal position to help patients impacted by domestic violence. As a healthcare provider, one does not need to be an expert in domestic violence to screen, communicate concern and validation, provide resources or a “warm” (person-to-person) referral, or create a safe space for disclosure at a later time.

Using this manual: Each chapter is intended as a stand-alone quick reference. Helpful resources for related topics to domestic violence are provided, although this manual is not a comprehensive document on child abuse and neglect, elder abuse, or human trafficking.

1 in 4
children have
witnessed violence in
the past year



2 in 5
teenagers have been
victims of assault,
bullying, and/or teen
dating violence



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

CHAPTER II: DOMESTIC VIOLENCE

A: DEFINITION AND SCOPE OF THE PROBLEM

Domestic violence is an abusive act or pattern of abuse – including verbal, physical, sexual, emotional, economic, or psychological actions or threats of acts – between family members, intimate partners, cohabitants, former intimate partners or cohabitants, and parents with a child in common, in which one party seeks to gain, maintain, or regain power and control over the other party. Acts of domestic violence include any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. Domestic violence occurs between family members and intimate partners indiscriminate of age, race, socioeconomic status, sexual orientation, gender identity, religion, education or disability. Domestic violence impacts patients, children, family members, friends, and entire communities.

B: CATEGORIES OF DOMESTIC VIOLENCE

INTIMATE PARTNER VIOLENCE (IPV)

Intentional pattern of coercive control used by one partner over the other in an intimate relationship. IPV can occur across all sexual orientations and gender identities. It does not require sexual intimacy.

TEEN DATING VIOLENCE (TDV)

Intimate partner violence that occurs when individuals are teens or adolescents.

NON-INTIMATE PARTNER VIOLENCE

Violence between individuals who are not intimate partners, but have a familial relationship, such as, parent/child, siblings, or grandparent/grandchild. Family members do not have to be biologically related.

C: TYPES OF ABUSE

Physical abuse, psychological abuse, emotional/verbal abuse, sexual violence, reproductive coercion, and economic/financial abuse are just a few types of abuse that constitute domestic violence. Some perpetrators may even use children, pets, or other family members as emotional leverage to force a patient into doing what an abuser wants.

Physical Abuse

Physical abuse involves the use of force by an abuser. It is important to note that physical abuse may or may not cause injury. Therefore, physical abuse includes many acts such as those which cause visible injury (e.g., stabbing or shooting), and those that may not (e.g. a punch targeting areas that are harder to bruise such as the abdomen or pelvis, pushing, shoving, pulling hair, and/or the use of restraints).

Psychological Abuse

Psychological abuse involves the abuser invoking fear through intimidation; threatening to physically hurt themselves, the patient's children, family, friends, or pets; destruction of property; isolating the patient from loved ones; and/or prohibiting the patient from going to school or work.

Emotional/Verbal Abuse

Emotional abuse involves the abuser saying or doing things to cause a patient to be afraid, lower the patient's self-esteem, manipulate, and/or control the patient's feelings or behavior. Emotional abuse involves invalidating or deflating the patient's sense of self-worth through constant criticism, name-calling, injuring the patient's relationship with their children, persistent insults, humiliation, or criticism.

Sexual Violence

Sexual violence is often an aspect of domestic violence. It includes not only sexual assault and rape, but also harassment, such as unwelcome touching and other demeaning behaviors. Sexual abuse is a broad term and can include reproductive coercion.

Reproductive Coercion

Behaviors that interfere with contraception use and/or pregnancy to include: explicit attempts to impregnate a partner against their wishes, controlling termination or continuation of a pregnancy, coercing a partner to have unprotected sex, and interfering with birth control methods.

Economic/Financial Abuse

Financial abuse is a common tactic used by abusers to gain power and control, and/or force a patient to become financially reliant on the abuser. The forms of financial abuse may be subtle or overt, but often include tactics of preventing a patient from earning finances or attending school, concealing financial information, limiting the patient's access to assets such as use of the family vehicle, ruining a patient's credit, and/or monitoring, reducing or denying access to finances. In some cases, financial abuse is present throughout the relationship and in other cases financial abuse becomes evident when the patient is attempting to leave or has left the relationship.

D: IDENTIFYING SURVIVORS AND PERPETRATORS

Who are the survivors?

- Anyone can be subject to domestic violence, you cannot tell just by looking at them.
- Domestic violence is present in all cultures, racial and ethnic groups, ages, religious affiliations, sexual orientations, and gender identities. And can span all income and education levels.
- Due to power and control tactics of abusers, your patient may appear to have difficulty keeping a job, maintaining contact with friends and family, and/or developing connections within their communities.
- Patients are the best judge of their safety and readiness to leave a relationship or seek help.
- Leaving a domestic violence relationship is the most dangerous time for a survivor and should not be done without planning and support.

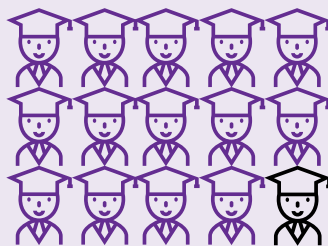
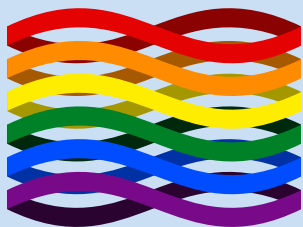
Who are the perpetrators?

- Anyone can be a perpetrator of domestic violence. You cannot tell if someone is an abuser just by looking at them.
- Perpetrators of domestic violence belong to all cultures, racial and ethnic groups; are of all ages, religious affiliations, sexual orientations, gender identities; and span all income and education levels.
- 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 possibly be violent solely within the abusive relationship.

E. WHY DOES DOMESTIC VIOLENCE OCCUR?

- Those who abuse make a choice to engage in abusive behavior because they can and it works to get what they want.
- Domestic violence is never caused by the survivor's behavior, the use of alcohol or drugs, stress, or mental illness.
- Violent and abusive behavior by a perpetrator, in some cases, can be the result of learned behavior, cultural values and/or historical precedent.
- Studies have found that some children who witness domestic violence grow up to have a greater risk of living in violent relationships themselves, either as survivors or as perpetrators.

LGBTQIA+ INDIVIDUALS ARE MORE LIKELY TO EXPERIENCE DV. THEY MAY STAY DUE TO SHAME OR FEAR OF BEING "OUTED."



ACCORDING TO A 2017 DELAWARE HIGH SCHOOL YOUTH RISK BEHAVIOR SURVEY, 14 OUT OF 15 STUDENTS EXPERIENCED TEEN DATING VIOLENCE IN THE PAST YEAR.

F: WHY SURVIVORS STAY

Leaving an abusive relationship does not guarantee an end to the abuse. Instead, the abuse often escalates at the time of separation. The most dangerous time for a survivor is when they attempt to leave or end the abusive relationship.

Fear

Economic Dependence

It's the Safest Option at the Time

Isolation

Shame

Hope for Change

Danger

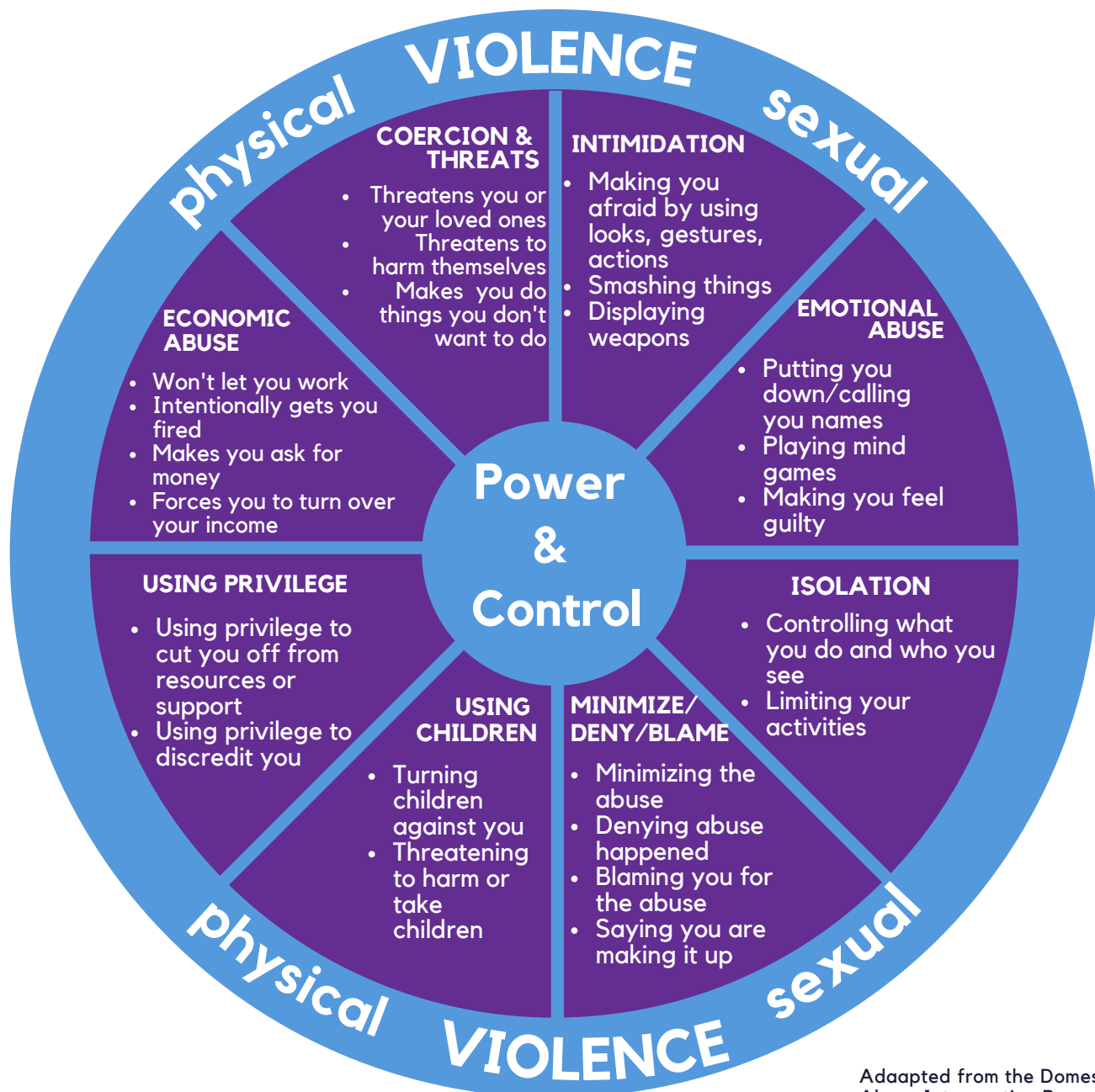
Religious/ Societal Pressures

Fear of Safety of Children

Past Failures of the System to Respond

G: POWER AND CONTROL TECHNIQUES

Domestic violence can take the form of physical and sexual violence; emotional, psychological and financial abuse; or a combination of various forms of abuse. Abuse is part of an intentional pattern and used by an abuser to gain power and control over a survivor. Below you will find a Power and Control Wheel which illustrates common tactics used by abusers to gain power and control over a survivor. Recognizing that abuse and power and control tactics present in many forms, multiple Power and Control Wheels have been developed to illustrate specific tactics used within different populations.



H: SIGNS AND SYMPTOMS OF DOMESTIC VIOLENCE

The effects of domestic violence on a patient's health go beyond the immediate physical injury a person may suffer at the hands of their abuser. Often, patients experiencing domestic violence suffer from an array of psychosomatic illnesses, insomnia, gastrointestinal disturbances, generalized chronic pain, mental health problems and long-term health issues that may be more difficult for a healthcare provider to identify as resulting from abuse.

PHYSICAL SYMPTOMS

Chronic Pain, Psychogenic Pain, or Exaggerated Pain Response

- Headache
- Atypical Chest Pain
- Abdominal Pain
- Gastrointestinal Issues

Symptoms of Depression

- Sleep and Appetite Disturbance
- Fatigue
- Concentration Difficulties

Genito-Urinary Problems

- STI
- Frequent UTI
- Dyspareunia
- Pelvic Pain
- Miscarriage/Vaginal Bleeding
- Premature Labor

Vague Neurological Symptoms

- Dizziness
- Paresthesia

“50% of women killed in intimate partner violence were seen by a healthcare provider within a year of their death.”

Aboutanos, Altonen and Vincent

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/or genitals
- Injuries during pregnancy
- Placental abruption
- Multiple sites of injury
- Injuries in various stages of healing
- Sexual assault
- Any bite marks
- Repeated or chronic injuries
- Injuries that are inconsistent with history
- Injuries consistent with strangulation (Also see chapter on Strangulation and TBI)

BEHAVIORAL INDICATORS

Patient Behavior

- Patient is evasive, frightened, or anxious
- Frequent visits or frequent missed/cancelled visits
- Explanation is inconsistent with normal physiology or inconsistent with injuries
- Prescription, alcohol, or other substance abuse problem
- Suicidal ideation, suicide attempt, or overdose

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
- Appointments cancelled by someone other than patient
- Also see Power and Control Wheel on page 7 of this manual for additional perpetrator behavior



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CHAPTER III: STRANGULATION AND TRAUMATIC BRAIN INJURY

A: PREVALENCE AND IMPACT

STRANGULATION

Pressure on the throat or the neck that results in restriction of oxygen and bloodflow to the brain. It can lead to anoxic-hypoxic brain injury, where the brain is injured by complete or partial loss of oxygen to the brain.

TRAUMATIC BRAIN INJURY (TBI)

Occurs when the brain is injured by rapid movement within the skull. TBI can change the way the brain normally works.

Partner inflicted brain injury occurs when a person's brain is hurt by lack of oxygen due to strangulation or blows to the head while experiencing domestic violence.

81% OF SURVIVORS REPORT

having been hit in the head or been made to have their head hit another object at least once

THE **MOST AT RISK** POPULATION FOR TBI ARE SOCIO-ECONOMICALLY DISADVANTAGED AFRICAN AMERICAN SURVIVORS

50% OF SURVIVORS REPORT

having been hit in the head so many times they lost count

Strangulation often leaves **no marks or any other external evidence** on the skin



83% OF SURVIVORS REPORT

having been strangled by an intimate partner at least once

Abusers who strangle are the most **deadly and dangerous**



Compared to **35% OF HETEROSEXUAL WOMEN** **61% OF BISEXUAL WOMEN** experienced physical abuse, particularly blows to the head and face.

50% of strangulation victims did not have any visible injury



TBI caused by physical violence is **30-50%** higher in Latinx, Hispanic and Asian-American survivors

B: PROGRESSION OF VIOLENCE AND HEALTH IMPLICATIONS

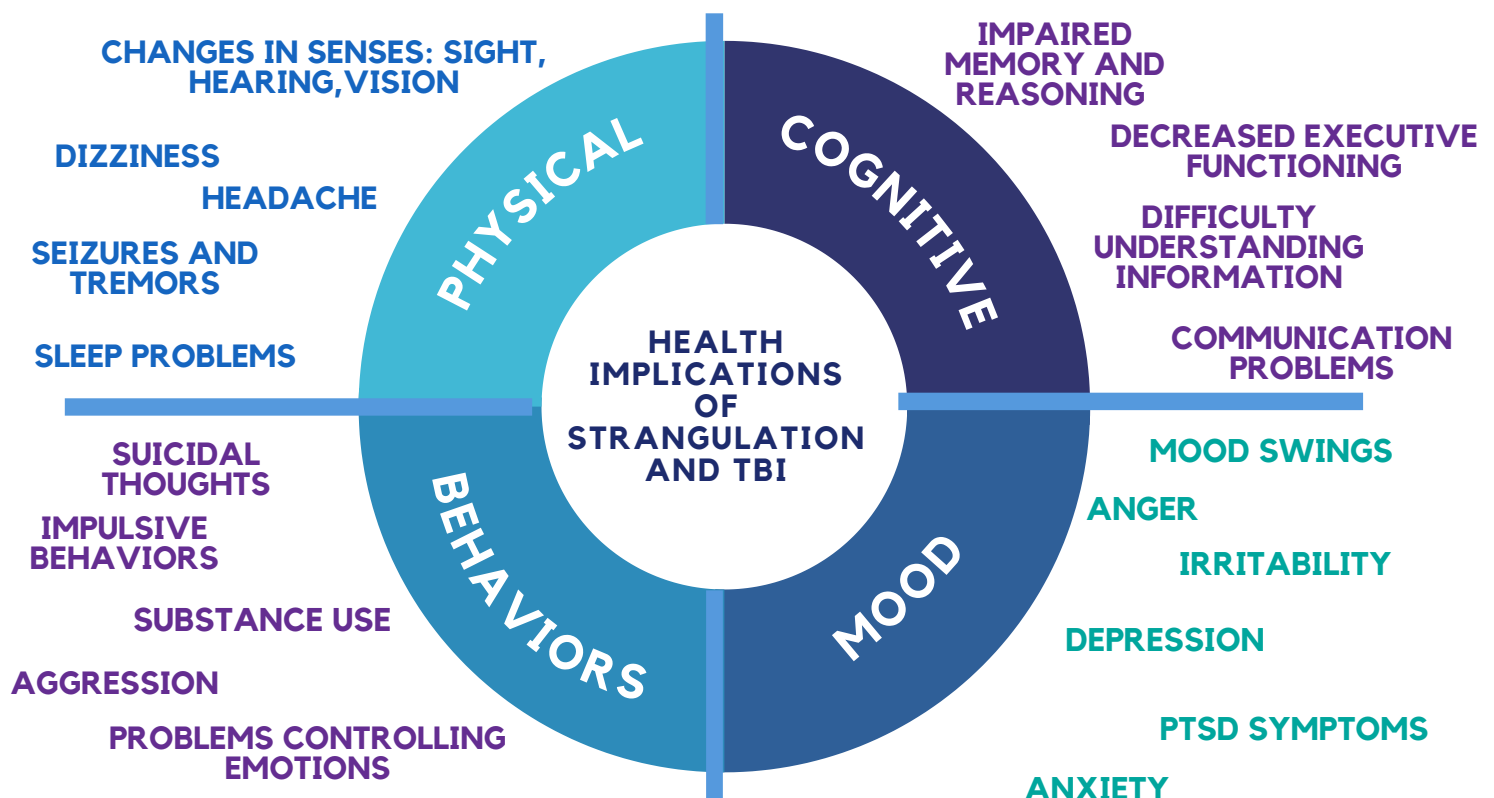
TBI is a life-altering condition that makes everyday life challenging and difficult. Its impacts and consequences are far-reaching, affecting survivors, their families, and communities.

PROGRESSION OF VIOLENCE



STRANGULATION

Strangulation is a significant risk factor for attempted or completed homicide by an intimate partner. If you suspect a patient has been strangled or if a patient discloses they have been strangled be sure to offer a domestic violence resource.



C: SIGNS, SYMPTOMS AND SCREENING

SIGNS OF STRANGULATION



DIFFICULTY OR PAIN WHEN BREATHING



DIFFICULTY SPEAKING



DIFFICULTY SWALLOWING

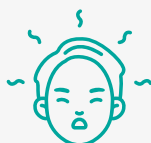


CHANGES IN VOICE

Patients are unlikely to use the word "strangulation." They are more likely to report strangulation as: 'choking', 'choking out', or 'getting beat up'.

SYMPTOMS OF TRAUMATIC BRAIN INJURY

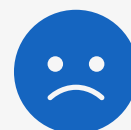
(MOST COMMONLY REPORTED)



PERSISTENT HEADACHES



DIZZINESS



DEPRESSION



MEMORY LOSS



FATIGUE OR WEAKNESS



DIFFICULTY REGULATING ANGER



DIFFICULTY UNDERSTANDING DIRECTIONS



DIFFICULTY UNDERSTANDING SPEECH AND/OR READING



SCREENING: HAS YOUR HEAD BEEN HURT?

If a healthcare professional suspects strangulation or possible brain injury, utilize the "HAS YOUR HEAD BEEN HURT?" screening tool.

HAS YOUR HEAD BEEN HURT?
Sometimes when people are abused their head gets hurt. This can cause injuries that aren't always obvious. Please answer the questions and talk with an advocate so we can help make services work best for you. We know how difficult it is to share this information – thank you for your courage. We are here to support you.

C Has anyone ever put their hands around your neck, put something over your mouth, or done anything else that made you feel **choked**, strangled, suffocated, or like you couldn't breathe? YES NO

H Have you ever been **hit or hurt** in the **head**, neck or face? YES NO

T After you were hurt, did you ever feel dazed, confused, dizzy or in a fog? YES NO

1. Series of 8 or less yes/no questions to assess:
 - Choking/trouble breathing
 - Head trauma
 - Altered consciousness
 - Troubles patient is experiencing
 - If the patient has seen someone or wanted to see someone about troubles
2. Includes questions on suicide, substance use, and other health concerns
3. Helps connect, identify, provide information, accommodate and support referrals

WWW.ODVN.ORG/WP-CONTENT/UPLOADS/2020/05/CHATSADVOCATEGUIDE.PDF

CHAPTER IV: SCREENING FOR DV

The clinical value of screening for domestic violence has been widely acknowledged. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires policies and procedures for identifying, treating, and referring patients experiencing domestic violence 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 early domestic violence and abuse to positively impact health outcomes for patients.

Healthcare settings are an optimal place to conduct screenings. Patients seeking care generally have some degree of trust in the healthcare system and often have ongoing relationships with their providers. Additionally, healthcare settings provide an opportunity for confidentiality and privacy. When screening for domestic violence, it is important to remember that neither affected patients, nor perpetrators of domestic violence, fit a distinct personality or profile. Abuse affects people of all ages, sexual orientations, gender identities, races and ethnicities, and socioeconomic classes. Best practice recommends implementation of universal screening rather than targeting a specific patient group.

Healthcare providers play a vital role in identifying patients who are impacted by domestic violence and supporting safety through screening, a trauma-informed response to disclosure, compassion and support, and providing resources or referrals. When healthcare providers screen patients for domestic violence and make referrals to relevant resources, they communicate their concern about the issue of domestic violence, validate patient experiences, reduce isolation, and provide an opportunity for patients to seek help.

Vulnerable populations experience domestic violence in different ways and in varying degrees of intensity based on social categorizations (such as race, class, gender identity, ability, and sexual orientation), which are interconnected and cannot be viewed independently.

.....

Regularly screening all patients is important because some patients do not disclose abuse the first time they are asked.

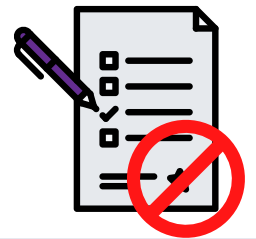
(Committee on Healthcare for Underserved Women, 2019)

A: OVERCOMING BARRIERS

Healthcare providers are well-positioned to implement universal domestic violence screening with patients, despite any barrier that may exist. While some barriers are procedural, others are specific to the healthcare provider's personal beliefs, experiences, or biases. Regardless of the cause, through education and commitment, all barriers must be overcome to allow for consistent, efficient, and effective screening of all patients.

Screening Fatigue

A rapidly increasing number of screening and assessment tools have produced benefits for clinicians and patients. Yet, the integration and mandatory use of numerous screening and assessment tools has left some HCPs feeling overwhelmed. Consequently, HCPs may approach patient screenings with a "checking the box" mentality.



HOW TO OVERCOME IT

Screening for domestic violence is an approach, rather than a check list. HCPs should think of the screening as a conversation rather than a list of questions. In doing so, screening for DV can be done seamlessly, within your current practice and/or electronic medical system.

Inability to Conduct Private Screenings

Due to a perpetrator's control tactics and a lack of physical space or process which allow patients to meet with a provider alone, conducting a private screening can be challenging.

HOW TO OVERCOME IT



Build private time into your regular process (i.e., the first 5-minutes of every visit is private).



Post signage so patients and their guests are aware of the universal protocol.



Be creative in finding unassuming ways to create private time (send the patient's guest to the front desk with a form).



Accept that there will be times that you aren't able to get your patient alone.



Do NOT screen for domestic violence when you cannot meet with a patient in private. It is unsafe to do so.

False Belief That Our Patients Are Not Impacted By Domestic Violence

The prevalence of domestic violence is often understated or misunderstood. As a result, healthcare providers may be less likely to recognize the signs and symptoms of domestic violence. Further, they may be less motivated to screen patients for domestic violence.

HOW TO OVERCOME IT

FACT

Regardless of the field of medicine, health care providers will undoubtedly encounter patients impacted by domestic violence.

FACT

Domestic violence impacts people of all races, religions, socioeconomic statuses, sexual orientations, and gender identities.

FACT

In Delaware, nearly 240,000 people have experienced domestic violence during their lifetime.

FACT

Members of LGBTQIA+ communities experience domestic and sexual violence at rates that are equal to or higher than non-LGBTQIA+ people.

Providers Fear They Will Offend Their Patients

HOW TO OVERCOME IT

Asking a patient about an unhealthy relationship should be no more difficult than asking patients about other personal topics such as sexual practices, diet, and substance use.

Not Sure How to Respond if Patient Screens Positive for DV or Discloses DV

HOW TO OVERCOME IT

Respect your patient's privacy, confidentiality, and level of detail offered.

Listen. Believe. Support.

Never give a DV resource without first asking if it is safe to take it.

Understand that the patient is the best authority on their own lived experience and an expert on their own safety.

Offer patient the option of privately calling the Domestic Violence Hotline on a phone belonging to the HCP, before they leave your office.

Have a conversation

"I am so sorry this happened to you."

"Thank you for sharing this with me."

"How can I help you?"

It is not necessary for the HCP to know every resource available. Refer to the Domestic Violence Hotline or a community resource, and allow trained professionals to further assist the patient. Resources are available 24/7.

B: CREATING A SAFE AND SUPPORTIVE ENVIRONMENT FOR SCREENING AND DISCLOSURE

There are several important steps you can take to create a safe and supportive environment for screening patients about domestic violence. These steps include:

CONDUCTING INTERVIEWS IN PRIVATE

- A patient needs to feel safe and secure in order to discuss their situation openly and honestly.
- Provide a private place to interview patients alone where conversations cannot be overheard or interrupted.
- Never assume that it is safe to ask questions concerning domestic violence in front of any other party.

FIRST, DO NO HARM “PRIMUM NON NOCERE”

- Conduct yourself in a way that encourages patients to use the healthcare system. You may be the first or last source of help a patient turns to.
- Maintain confidentiality: Delaware law does not require mandatory reporting of domestic violence. ***Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent and can put a patient at increased risk of harm and lethality.***
- Missing the signs of domestic violence, similar to overlooking a diagnosis of pneumonia, diabetes, or peptic ulcer, is a missed opportunity to assist the patient in dealing with a health risk. Even if you are unsure of whether your patient is affected by domestic violence, document that you screened, the patient's response, and note any details of the abuse and health consequences. Still offer the patient resources for themselves or a friend ([For more information see Confidentiality chapter.](#))

While disclosure is never the goal, when asked in private, screening creates a safe space for disclosure.

SUPPORTING AND RESPECTING THE PATIENT

- Practice Trauma Informed Care by promoting a culture of safety, empowerment, and healing.
- It is particularly important that our patients receive our support – we may be the only ones in their corner.
- Do not assume the biological sex on a patient's chart is the gender they identify as. Always ask for a patient's preferred name and pronouns.
- Be proactive around the use of gender pronouns (i.e., introduce yourself using your pronouns and include your pronouns on your ID badge).
- Do not make assumptions about the gender of your patients' partner(s). Use gender-neutral terms when referring to patients' partner(s) such as "they".
- The goal is not disclosure. A screening is a success, if a patient simply starts thinking about the effects of DV on their health, and/or accepts information or resources for themselves or a friend, and/or starts talking about the violence, and begins to explore their options.
- Respect your patient's privacy, confidentiality, and level of detail offered. Ask only medically necessary questions.
- A patient knows when the safest time to leave a relationship is.
- Recognize there are valid reasons for maintaining a relationship and barriers to leaving.
- Allow patients to talk about their ambivalence to leaving.
- Recognize that some patients return to their partners several times. ***This is not a failure; safely leaving an abusive partner is a process.***

AVOIDING BLAME AND JUDGMENT

- Avoid assigning any blame. Ask questions in a nonjudgmental manner.
- Avoid the stigmatizing terms such as "battered," "abused," or "victim of domestic violence," as patients often do not see themselves in that regard.
- Use a strategy that does not convey judgement and one that you are comfortable with.

Best Practice Tip:

It is not necessary to question a patient about their trauma history. Instead, HCP should assume all patients have experienced trauma and take a trauma informed approach to care.



.....

Transgender victims are more likely to experience intimate partner violence in public, compared to those who do not identify as transgender

(National Coalition Against Domestic Violence)

PROVIDING RESOURCES

- Never give a resource unless you ask if it is safe for the patient to take it.
- Have information including hotline numbers, safety cards, and resource cards on display in common areas and in private locations for patients, such as bathrooms and exam rooms.
- Display educational posters addressing domestic violence and healthy relationships that are multicultural and multilingual in bathrooms, waiting rooms, exam rooms, hallways, and other highly visible areas.
- Refer to the Domestic Violence Hotline or community resources and allow those trained professionals to further assist the patient. Remember, it is not necessary for the HCP to know every domestic violence resource available.
- Offer patients the option of privately calling the Domestic Violence Hotline or community resources before they leave your office. Some patients will not have the privacy or means to make the phone call outside of the medical facility safely. 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.
- Familiarize yourself with local and national LGBTQIA+ specific resources.

PRACTICING CULTURAL HUMILITY

Improving cultural understanding and sensitivity to the unique needs of domestic violence survivors is critical. This includes conducting screenings with cultural humility and adapting your assessment questions and approach to be culturally relevant to individual patients.

- Be able to recognize and appropriately address racial and gender biases in yourself, others, and the delivery of healthcare services.
- Recognize and understand culture as an asset and not a barrier.
- Use inclusive and culturally relevant language.
- Listen to patients, pay attention to words that are used in different cultural settings and integrate those into assessment questions.
- Be aware of verbal and non-verbal cultural cues (eye contact or not, patterns of silence, and spacing).

Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for [patients] to take the information without disclosure.

(Futures Without Violence)

.....

LGBTQIA+ African American victims are more likely to experience physical intimate partner violence, compared to those who do not identify as Black/African American.

(National Coalition Against Domestic Violence)

C: UNIVERSAL EDUCATION AND SCREENING FOR DOMESTIC VIOLENCE

The approach used in screening for domestic violence contributes more to the efficacy of screening than the content of questions or type of screening tool used (i.e. written, electronic, verbal). Whether using a screening tool contained within an electronic medical record or creating one of your own, screening for domestic violence should not be cumbersome and the goal should never be disclosure. Long lists of questions may impede the process, discourage effective universal screening, and create a “checking the box” mentality for providers.

To conduct effective and safe screenings, consider using the Confidentiality, Conversation, Connect approach. Adapted from the Futures Without Violence CUE’s model, the Confidentiality, Conversation, Connect approach is the best practice. It is an easy-to-follow screening model that providers can use within their existing electronic medical records and practices. As part of the model, and in the case of a positive screen or a disclosure, a healthcare provider can provide resources or make a “warm” (person-to-person) referral to an available community domestic violence resource. In doing so, providers can minimize disruption of the clinical setting while still assuring that the patient will get the help that they need.



UNIVERSAL SCREENING

○ — Confidentiality

○ — Conversation

○ — Connect

STEP 1: CONFIDENTIALITY

- Always review the limits of confidentiality, before doing any assessments. (See Chapter on Confidentiality)
- Assess only when the patient is alone, without parents, partners, or children.

Sample Language:

"Before I get started, I want you to know that everything we talk about is confidential, meaning I won't talk to anyone else about it, unless you tell me about someone who is going to hurt themselves or abuse of someone who cannot speak for themselves."



REPORTING REMINDER:

Delaware law does not require mandatory reporting of domestic violence. **Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent.**



STEP 2: CONVERSATION

- While assessment questions for domestic violence may be contained in self-administered questionnaires or computerized interviews, having a conversation should also be a part of the face-to-face assessment.
- Start the conversation by normalizing the activity to reduce stigma and promote empowerment.
- Do not make assumptions about the gender of your patients' partner(s). Use gender-neutral terms when referring to patients' partner(s) such as "they."



Sample Language:

"We've started talking to all of our patients about safe and healthy relationships, since it can impact your health. We routinely give out resources, if you or a friend need information."



Best Practice Tip:

Make sure it's safe for your patient to take resources and information with them when they leave your care. Always give two copies of resources to promote helping others.



STEP 3: CONNECT

- **Provide a warm referral to domestic violence services, if necessary.**
- **Follow up with the patient at their next visit.**
- **It is not necessary for the healthcare providers to know every domestic violence resource available. Refer to the Domestic Violence Hotline or a community DV resource, and allow those trained professionals to further assist the patient. There are resources available 24/7.**



Sample Language:

"If you're comfortable with it, I'd like to connect you with a domestic violence advocate who you can talk to. I refer a lot of my patients to them because I trust them. Would you like to make the call together?"



Best Practice Tip:

If the patient discloses abuse, coercion, or other domestic violence, validate their feelings and concerns. Ask if they have immediate safety concerns and discuss options. Refer to a Domestic Violence Hotline, for safety planning and additional support.



24-HOUR DOMESTIC VIOLENCE HOTLINES



(302) 762-6110 : New Castle

(302) 678-3886 : Sussex

(302) 244-8058 : Kent

(302) 745-9873 : Bi-lingual

**ADDITIONAL RESOURCES CAN BE FOUND AT
THE END OF THIS MANUAL**

UNIVERSAL SCREENING TIPS AND TRICKS

SAMPLE QUESTIONS TO ASK:



- “Has your partner or someone important to you ever threatened you or made you feel afraid?”
- “Has your partner or someone important to you ever threatened to hurt you or your children if you did or did not do something, controlled who you talked to, or where you went, or gone into rages?” (The Family Violence Prevention Fund)
- “Has your partner or someone important to you ever hit, choked, or physically hurt you? Hurt includes being hit, slapped, kicked, bitten, pushed, or shoved and may or may not include bruises, wounds, or visible injury.”



WHEN TO SKIP SCREENING QUESTIONS:

- If the healthcare provider cannot secure a private space in which to conduct inquiry.

IF A SCREENING DOES NOT OCCUR:

- Note in chart that inquiry was not completed and schedule a follow-up appointment (or if in an urgent care setting, refer patient to a primary care provider).
- Have posters, safety cards, and patient education materials about domestic violence available in exam or waiting rooms, and bathrooms.

REPORTING REMINDER: Delaware law does not require mandatory reporting of domestic violence. Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent.



D: SAFETY SCREENING



The Family Violence Prevention Fund recommends healthcare providers conduct an initial safety screening immediately after a patient's disclosure. Safety includes the well-being of the patient, children, loved ones, and pets, and can be assessed in a short period of time. The goals of safety screenings are to a) create a supportive environment where the patient can discuss the abuse, b) enable the provider to gather information about health problems associated with the abuse and c) assess the immediate and long-term health and safety needs for the patient, in order to develop and implement a response. Providers should have ongoing conversations about safety and healthy relationships in subsequent appointments. The Family Violence Prevention Fund also recommends that providers offer at least one follow-up appointment (or referral) with the provider, social worker, or DV advocate for patients who screen positive for domestic violence.

What should a safety screening include?

For the patient who discloses current abuse, screening should include the following three steps, at a minimum:

01 **Assessment of Immediate Safety**

Inquire with your patient about any immediate safety concerns they may have. According to the Family Violence Prevention Fund in 2004, some sample questions include:

- 
- "Are you in immediate danger?"
 - "Is your partner here with you now?"
 - "Do you feel safe going home with your partner?"
 - "Do you have somewhere safe to go?"
 - "Are you afraid your life may be in danger?"
 - "Has your partner threatened to kill you, themselves, or your children?"
- 

02 **Assessment of the Impact of DV (Past or Present) on Health**

Providers should have ongoing conversations about safety and healthy relationships in subsequent appointments. Disclosure should prompt providers to consider healthcare risks and assess accordingly.

03 Referral to a DV Resource for Further Safety Planning

Encourage your patient to call a domestic violence resource before they leave your office for further safety planning. Let the patient know you are worried about their safety and that you trust the domestic violence advocates. If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats AND they are declining to call a domestic violence resource, providers may consider offering information about the emergency room as a place that the patient could show up anytime and be able to ask for help in the future.

CAUTION: Avoid the temptation to refer to the ED simply because of discomfort addressing DV or fear of not having comprehensive services; rather provide a safe place and refer to community advocates who can help your patient access appropriate services. Be aware that if the patient declines resources, this is not a failure and not an indication for an ED visit.

APPROPRIATE ALTERNATIVE

If a patient is in an unsafe situation, but does not wish to speak to a domestic violence resource, respect their decision. As an alternative, providers can ask some of the below questions to help the patient make a plan for safety.



WHAT TO ASK BEFORE A PATIENT LEAVES: ASK THE QUESTIONS, MAKE A PLAN

1. How can you get out of the home safely if a situation becomes violent? Where are 2 safe places you could go if you had to get out quickly?
2. Where can you keep your wallet, keys, bag, etc. in order to get to them quickly if you need to leave your home? Can you leave a bag with keys, money, and personal items with a safe person in case you have to leave?
3. Can you teach your children to use all the phones in the home to call 911?
4. Can you teach your children and 2-3 safe people a code word you can say and they will know to call 911?
5. Can you teach your children your name and phone number and a safe person's name and phone number?
6. Can you purchase an escape ladder for a second story window?
7. Can you install smoke detectors and fire extinguishers on every floor of your home?
8. What can you do if something unsafe happens while you are driving to or from work?
9. Can you purchase a prepaid/pay per minutes/burner phone to make calls on?
10. Can you program a 24/7 Domestic violence hotline number into your phone?

Remember, the patient is the expert on their safety and their abuser. They know if it's not safe to use a resource and/or implement any of these safety tips. Respect their choices on how they keep themselves and their children safe.

**YOU CAN ALWAYS CALL A 24/7 DOMESTIC VIOLENCE
HOTLINE TO HAVE AN ADVOCATE HELP THE PATIENT
MAKE A SAFETY PLAN.**

CHAPTER V: LEGAL MANDATES

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.

Note to Reader

It is best practice to avoid stigmatizing terms such as "battered," "abused," or "victim." To be consistent with the legal statutes and codes referenced in this chapter, this section uses such terms.



WHY MANDATORY REPORTING OF DOMESTIC VIOLENCE IS NOT REQUIRED

SAFETY	AUTONOMY	HEALTHCARE CONSEQUENCE
Reporting often increases the level of violence, risk of harm and lethality.	Individuals should be free to make their own choices as to whether or not to report.	Some patients are prevented from seeking medical attention, unless they promise they will not reveal the source of their injuries.
Escaping a violent relationship is a process that requires the resolution of complex issues such as housing, financial self-sufficiency, and protecting any children from abuse or abduction. It may take the patient months or even years to resolve these complex issues.	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.	Mandatory reporting could discourage patients from disclosing accurate details and the extent of injuries, or even from seeking care.
Mandatory reporting of injuries may cause a patient to flee prematurely, before a safety plan can be fully implemented. Premature flight can increase the risk of serious injury and homicide.	People who are injured as a result of domestic violence need medical attention, emotional support, and non-judgmental information about their options.	Patients may not feel safe seeking medical treatment if they have had a negative experience with a HCP or hospital reporting to law enforcement or DFS in the past.

A: WHEN IS MANDATORY REPORTING REQUIRED?



REPORTING REMINDER: Delaware law does not require mandatory reporting of domestic violence. Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent.

Mandatory reporting is required for the following:

Suspected child abuse - 16 Del. C. §903

Reportable to Delaware Division of Family Services (DFS) by calling **1-800-292-9582**

Abuse, neglect, mistreatment, or exploitation of a vulnerable or impaired adult - 31 Del. C. §3910

Reportable to Adult Protective Services (APS) Aging and Disability Resource Center by calling **1-800-223-9074**

Suspected abuse, neglect, mistreatment, or financial exploitation of residents or patients living in a long-term care facility - 16 Del. C. §1132

Reportable to Division of Healthcare Quality by calling **1-877-453-0012**

Suspected financial exploitation of a person 62 years or older - 31 Del.C. §3902 (12)

Reportable to Adult Protective Services Aging and Disability Resource Center by calling **1-800-223-9074**

All 2nd or 3rd degree burns over 5% of the total body surface or any significant respiratory tract burn - 16 Del. C. §6614 (f)

Reportable to the appropriate police authority where the attending or treating person was located at the time of treatment

All non-accidental poisoning - 24 Del. C. §1762

Reportable to the appropriate police authority where the attending or treating person was located at the time of treatment

All stab wounds - 24 Del. C. §1762

Reportable to the appropriate police authority where the attending or treating person was located at the time of treatment

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

Reportable to the appropriate police authority where the attending or treating person was located at the time of treatment

B: DOMESTIC VIOLENCE AND CHILDREN

While Delaware law does not require mandatory reporting of domestic violence, cases of domestic violence involving children must be reported to DFS at 1-800-292-9582, **when** a child is experiencing (16 Del. C. §903):

Physical Harm —

child is injured; child is suspected to be injured due to use of a weapon or potentially dangerous object; or child has attempted to physically intervene

Emotional Harm—

child is aware (sight or sound) of an incident perpetrated against his/her caregiver **AND** it involves a significant injury to the victim or use of a weapon; **AND** child has a diagnosed mental health condition or behaviors that signify severe psychological harm

See chapter on Children and Domestic Violence for more information.

C: DOMESTIC VIOLENCE BETWEEN DATING MINORS

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

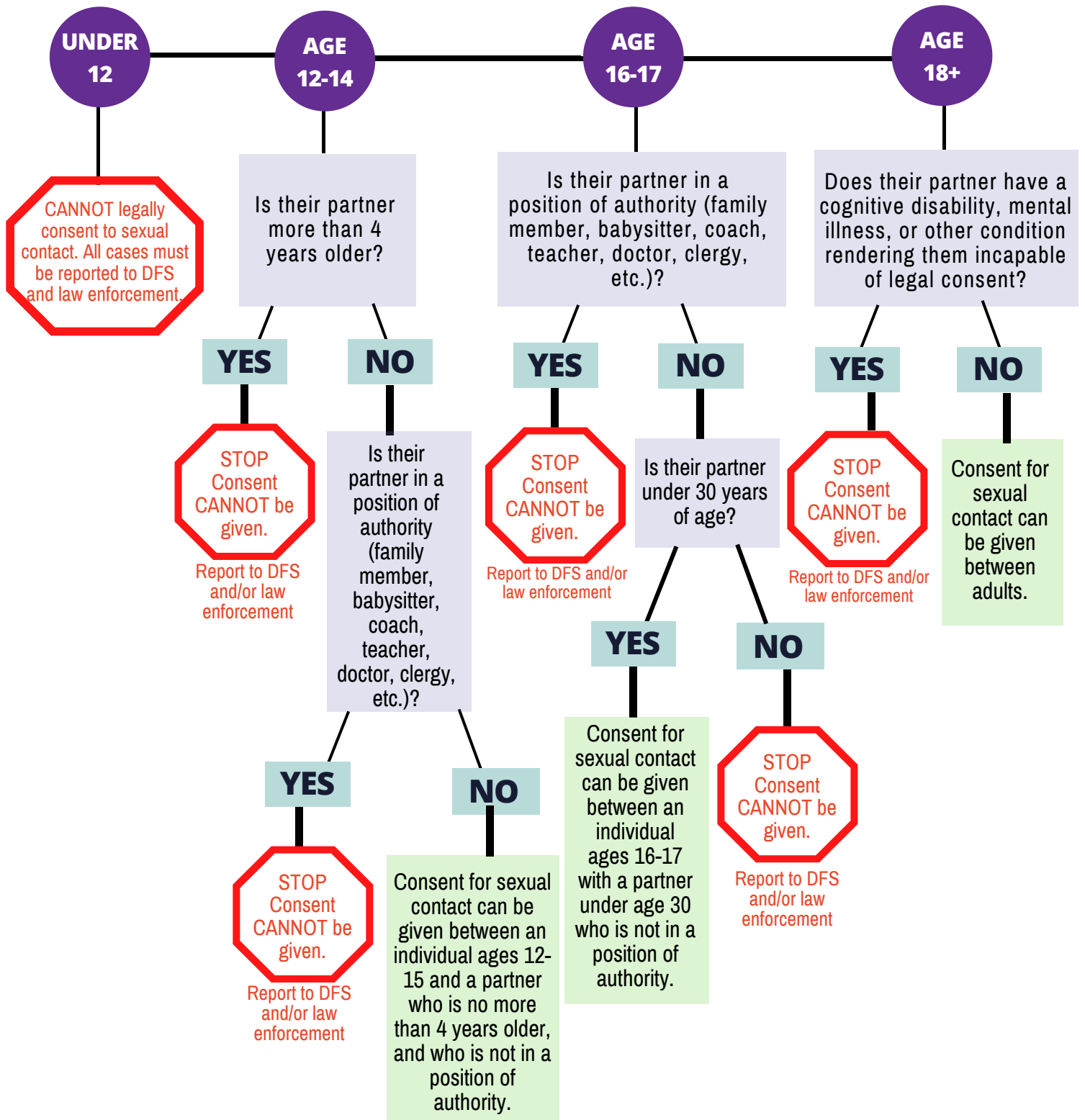
- 01 Committed an act that would fall under any of the seven categories in Section A above or
- 02 Committed an act of sexual abuse or sexual assault against their underage partner or
- 03 Commits one of the acts above while having “care, custody or control” of the minor partner. For example a babysitter or coach.

Note: “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)**



D. HOW TO DETERMINE AGE OF CONSENT FOR SEXUAL CONTACT

HOW OLD IS THE INDIVIDUAL?



E: VULNERABLE ADULTS REPORTING REQUIREMENTS



REPORTING REMINDER: Delaware law does not require mandatory reporting of domestic violence. **Except in circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent.**

In the State of Delaware, there is **MANDATORY REPORTING** for healthcare professionals and mental health professionals when they suspect an adult who is impaired or incapacitated is in need of protective services (31 Del.C. §3910).

31 Del. C. § 3910 Duty to Report

(a) Any person having reasonable cause to believe that an adult person is impaired or incapacitated as defined in §3902 of this title and is in need of protective services as defined in §3904 of this title shall report such information to the Department in the manner and format published by the Department.

It is important to remember that Adult Protective Services (APS) not only offers investigative services, but also provides direct services and referrals for individuals in need of help. On a voluntary basis, they can provide services to older individuals, 60 and older, that will help stabilize a patient's situation. APS will not force a person to move or do anything that they do not want to do. APS is a resource to help older adults and persons with disabilities live in a safe, healthy environment and receive the services they need.



**ADULT PROTECTIVE SERVICES (APS)
AGING AND DISABILITY
RESOURCE CENTER
1-800-223-9074**



DEFINITIONS FOR VULNERABLE ADULTS

01 **"Older Individual"**

is defined by the older Americans Act of 1965 [As Amended Through P.L. 114-144, Enacted April, 2019] as "an individual who is 60 years of age or older."

02 **"Adult who is impaired"**

is defined by 31 Del.C. § 3902(2) as "...any person 18 years of age or over who, because of physical or mental disability, is substantially impaired in the ability to provide adequately for the person's own care and custody."

03 **"Person who is incapacitated"**

is defined by 31 Del.C. § 3902(19) as "a person for whom a guardian of person or property, or both, shall be appointed," under §3901 of Title 12.

04 **"Physical or mental disability"**

is defined by 31 Del.C. § 3902(20) to include any physical or mental disability and shall include, but not be limited to, intellectual and developmental disabilities, brain damage, physical degeneration, deterioration, senility, disease, habitual drunkenness or addiction to drugs, and mental or physical impairment.

05 **"Substantially impaired in the ability to provide adequately for the person's own care and custody"**

is defined by 31 Del.C. § 3902(23) as person who is impaired is unable to perform or obtain for themselves essential services.

F: VULNERABLE POPULATIONS AND MANDATED REPORTING CONSIDERATIONS

Healthcare providers are **NOT** required to make a report of domestic violence to adult protective services unless the patient is **substantially impaired** or **incapacitated**. Healthcare providers are encouraged to make a **referral** to APS for patients who are not substantially impaired or incapacitated but still may benefit from APS services.

AGE 60 +	SUBSTANTIALLY IMPAIRED	APS REFERRAL	WHEN TO REFER
<p>The fact that someone is over a certain age <u>DOES NOT</u> automatically trigger a mandated report to Adult Protective Services (APS).</p>	<p>A person who is substantially impaired is defined as any person 18 years of age or over who, because of physical or mental disability, is unable to perform or obtain essential services to provide adequately for their own care and custody.</p>	<p>Adult Protective Services (APS) offers direct services and referrals for people over 60 in need of assistance. Services include: medical or mental health evaluations, legal referrals, relocation assistance, transportation and much more!</p>	<p>If you suspect or your patient has disclosed domestic violence, offer a domestic violence resource such as a DV hotline.</p>
<p>There is no law which mandates HCPs to report abuse of elderly persons residing in the community.</p>			<p>For patients over the age of 60, you can also refer to APS services and refer to the Aging and Disability Resource Center (ADRC) by calling 1-800-223-9074.</p>
<p>DE Code only requires HCPs to report suspected abuse of a person who is <u>substantially impaired</u> or <u>incapacitated</u>.</p>	<p>INCAPACITATED</p> <p>A person who is incapacitated is defined as a person for whom a guardian of person or property, or both, shall be appointed.</p>	<p>All APS services are voluntary. HCPs are encouraged to talk to patients about the services APS provides and refer, as needed, to the Aging and Disability Resource Center (ADRC) by calling 1-800-223-9074.</p>	<p>Unless mandated to report, always respect confidentiality and never call a resource without your patient's permission.</p>

G: WHO IS REQUIRED TO REPORT?

The chart below provides a quick summary of who is required to report, the corresponding laws, and resources for providers to use.

WHAT MUST BE REPORTED?	ANY PERSON	MENTAL HEALTH PROFESSIONAL/ SOCIAL WORKER	HCP	CITATIONS	RESOURCES
Child abuse (see above parameters)	✓	✓	✓	Del. Code tit. 16 §901 et seq.	<u>Resource Guide for Mandatory Reporting of Child Abuse & Neglect in Delaware</u>
Financial exploitation of elder or abuse of incapacitated or impaired person	✓	✓	✓	Del. Code tit. 31 §3910	<u>Delaware Services for Aging Adults and People with Disabilities, Adult Protective Services</u>
Stabbings, non-accidental poisonings and gunshot wounds			✓	Del. Code tit. 24 §1762	

H. TRAUMA-INFORMED REPORTING

When healthcare providers are required to report abuse, often against their patients wishes, there is a risk of trauma or re-traumatization to a patient. As a result of the report, patients may feel a loss of control and experience feelings of helplessness, or even frustration. Healthcare providers should be aware of these risks and exercise trauma-informed reporting when making mandated reports. Trauma-informed reporting involves informing and involving patients in the reporting process.

INFORM

If you are mandated to report, inform your patient of what steps you are going to take, who you will call and/or involve, what information you will share, and any other factual information about the process. Providing clear expectations can reduce the re-traumatization of the patient and decrease feelings of helplessness.

BEST PRACTICE TIP: Prior to conducting assessments or screenings, healthcare providers should always review their limits of confidentiality with their patients. (See Universal Screening section)



INVOLVE:

Invite your patient to make the call to report, join you on the call, or listen in on the call. Be sure to report any concerns your patient has (e.g., if their partner were to find out about the report).



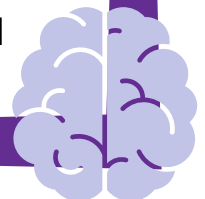
Sample Language:

"Based on what you have told me, a report has to be made, but you are welcome to listen in as I call in the report, so you know what is being said and there are no surprises. I'd also like you to add any questions or concerns you have."



BEST PRACTICE TIP:

Offer to connect your patient with a domestic violence resource to create a safety plan around potential retaliation by their partner after a report is made (Futures Without Violence Trauma Informed Reporting).



CHAPTER VI: SEXUAL ASSAULT AND SEXUAL VIOLENCE

A: PREVALENCE AND IMPACT

WHAT IS SEXUAL VIOLENCE?

Sexual violence is a non-legal, all-encompassing term for forms of non-consensual sexual activity and related behaviors that cause harm. Sexual violence can be thought of as an umbrella term for all sexual behaviors that happen without someone's consent. All of the forms of violence, whether they are physical or not, fall under this umbrella.



16.2%

of adult women in Delaware reported having been forced into non-consensual sex at some point during their lives

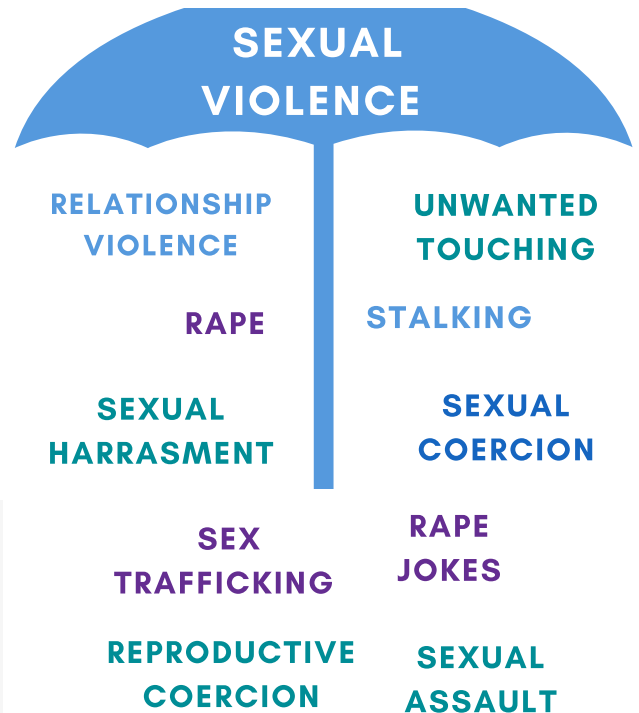
4%

of adult Delaware men reported that they had at some time been forced to have sex without their consent

33%

of rapes are committed by a current or former spouse, boyfriend, or girlfriend

Nearly **1 in 2 women and 1 in 5 men** experience sexual violence victimization other than rape during their lives



CONSEQUENCES OF SEXUAL VIOLENCE CAN INCLUDE...



FLASHBACKS
AND
DIFFICULTY
SLEEPING



SUBSTANCE
AND
ALCOHOL
ABUSE



DEPRESSION



SUICIDE
AND SELF
HARM



PTSD



PANIC
ATTACKS

B: REPRODUCTIVE COERCION

Reproductive coercion is a form of power and control where one partner strips the other of the ability to control their own reproductive system and timeline. It can be difficult to identify reproductive coercion because other forms of abuse are often occurring simultaneously.

PREGNANCY PRESSURE & COERCION

Forcing a partner to terminate a pregnancy

Forcing a partner to carry a pregnancy to term

Threatening harm to a partner who does not agree to become pregnant

Injuring a partner in a way that may cause a miscarriage

CONTRACEPTIVE SABOTAGE

Withholding, hiding, or destroying contraceptives

Intentionally breaking or poking holes in condoms

Not withdrawing when agreed upon

Removing IUDs, contraceptive patches, and vaginal rings

SEXUAL COERCION

Repeatedly pressuring a partner to have sex

Threatening to end a relationship if the person does not have sex

Forcing sex without a contraceptive

Intentionally exposing a partner to a STI

THE FACTS

15%

OF WOMEN WHO EXPERIENCE PHYSICAL VIOLENCE REPORT BIRTH CONTROL SABOTAGE

HOMICIDE

THE MAJORITY OF PREGNANCY-ASSOCIATED HOMICIDES WERE COMMITTED BY AN INTIMATE PARTNER

C: SCREENING AND DISCLOSURE

Sexual and domestic violence are often co-occurring. A patient may disclose experiences with one or both forms of violence. It's important to be prepared to have a conversation, practice a trauma-informed response and connect the patient to resources.

SCREEN AS PART OF ROUTINE VISITS

Well Women Visits
Annual Physicals
OB-GYN Appointments
Emergency Room Visits
Prenatal and Postpartum Appointments



PRACTICE TRAUMA-INFORMED SCREENING

Always review confidentiality limits before screening

Begin with general questions to assess comfort level

Screen in a private place, away from anyone else

Use a universal education approach



RESPONDING TO DISCLOSURES AND REPORTING

Believe any disclosure!

Show support and concern.

Let the patient know it was not their fault and you do not blame them.

Reassure them they are not alone and help is available.

"I'm so sorry that happened to you. It's not your fault."

"I'm worried about your safety. Can I connect you with some resources?"

"Thank you for sharing this with me. I believe you and I'm here to help however I can."

"You are not alone in this. There are many people who have gone through this."

If you must make a report, let the patient know and make a safety plan with a domestic violence or sexual assault advocate

Follow trauma-informed reporting guidelines.

D: SEXUAL ASSAULT NURSE EXAMINERS

Sexual Assault Nurse Examiners, or S.A.N.E.s, are specially trained nurses to work with survivors of sexual violence. S.A.N.E.s are trained in a trauma-informed approach, evidence collection, strangulation, and many other areas to best serve survivors after an assault.

WHAT SEXUAL ASSAULT NURSES EXAMINERS CAN DO



DISCUSS THE
PATIENT'S WISHES
AND WHAT THEY
ARE COMFORTABLE
WITH



PERFORM A
FORENSIC
MEDICAL
EXAM



COLLECT
EVIDENCE



CONTACT LAW
ENFORCEMENT IF
PATIENT WISHES OR IF
MANDATED



CONNECT
PATIENT TO
COMMUNITY
BASED
SUPPORTS

FACTS ABOUT S.A.N.E. KIT COLLECTION



Once collected, patients may take up to **6 months** to decide whether or not to report to law enforcement. After 6 months, if a report is not made the S.A.N.E. kit is destroyed.



A report will be made against a patient's wishes for patients under 18 or when a mandated report is warranted.



5 DAYS

Sexual Assault Forensic Kits can be collected up to 5 days (120 hours) after an assault has occurred. Even if a patient has changed clothes, showered, brushed teeth, etc.



If reported to police, patients will be referred to police-based victim services in addition to community-based support.



Patients have a right to a S.A.N.E. exam at no cost to them.



Patients can choose to decline a forensic kit but accept a S.A.N.E. exam and receive preventative medication for HIV, STIs, and pregnancy.



Medications will be offered to patients concerned about pregnancy, HIV or STI exposure.



Preventive medication is most effective if it is taken within the first 72 hours after the assault

CHAPTER VII: TEEN DATING VIOLENCE

A: PREVALENCE AND IMPACT

Teen dating violence (TDV) is a type of domestic violence that occurs between two teens or adolescents in a close relationship. TDV, also sometimes referred to as "dating violence," can take place in-person or electronically, such as through social media, phone apps and may look like repeated texting, posting sexual pictures of a partner online without consent, checking a partner's phone or stalking.

1 in 10 high school students has been purposefully hit, slapped, or physically hurt by an intimate partner



1 in 4 teens



**ARE HARRASSED
ONLINE BY A
DATING
PARTNER**



PREVALENCE BY AGE ¹

12 y.o.

14 y.o.

16 y.o.

18 y.o.

20 y.o.

Teens age 12- 18 experience the highest rates of rape and sexual assault

Teens age 18- 20 experience the highest rates of stalking

Experiencing relationship violence as a young adult increases the likelihood a person will experience intimate partner violence as an adult

2018-2019 INCIDENTS OF DATING VIOLENCE/SEXUAL ASSAULT IN DELAWARE PUBLIC SCHOOLS

161

total incidents reported by Districts and Charters

137

reports of sexual harassment

41

of the students identified as victims were classified as students with a disability

23

reports of unlawful sexual contact



B: SIGNS AND SYMPTOMS

TYPES OF TEEN DATING VIOLENCE



EMOTIONAL

Behaviors that serve to humiliate or embarrass, threats, coercion, name calling, blaming, controlling social life



PHYSICAL

Any type of punching, hitting, kicking, pushing, pinching, or use of weapon to control or make threats



STALKING

Tracking, following or monitoring electronically, physically, or through third parties



SEXUAL

Forcing someone to engage in any sexual act without consent. This includes coercion, pressuring or using a partner's sexual history to shame them

WHAT TO LOOK FOR

EXPERIENCING VIOLENCE

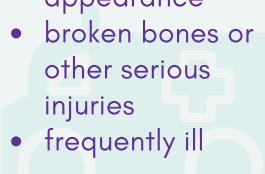
ACADEMIC

- poor academic performance
- no longer participates in school activities
- frequent absences
- loss of interest in favorite subjects
- academic probation



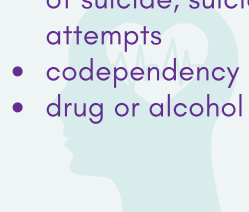
PHYSICAL

- sudden weight loss or weight gain
- pregnancy, STIs
- bruises or scratches
- decline in personal appearance
- broken bones or other serious injuries
- frequently ill



EMOTIONAL

- angry outbursts
- frequent crying
- "flat" demeanor or very energized, overly sexualized
- depression, anxiety, self-harm, thoughts of suicide, suicide attempts
- codependency
- drug or alcohol use



SOCIAL

- isolation from usual social groups or activities
- requests changes in class schedule to be with the abuser
- more conflict with others
- less communication with parents
- deleting social media accounts



PERPETRATING VIOLENCE

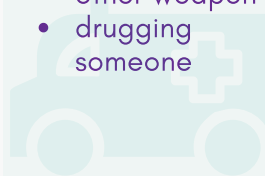
EMOTIONAL

- jealousy
- prevents contact with friends
- accusations of cheating
- name calling
- threats
- shaming
- "you can't do anything right"
- gaslighting



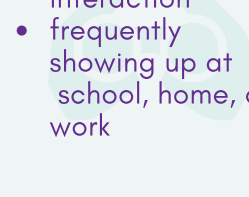
PHYSICAL

- pushing or pulling
- slapping or hitting
- pinching or biting
- strangulation
- holding someone down
- gun violence
- use of knife or other weapon
- drugging someone



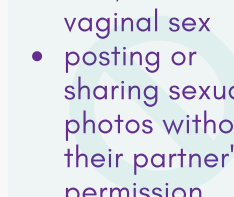
STALKING

- monitoring a partner online using social media or GPS
- unwanted, inappropriate gifts
- repeated texting, messaging, or calling attempts
- manipulating interaction
- frequently showing up at school, home, or work



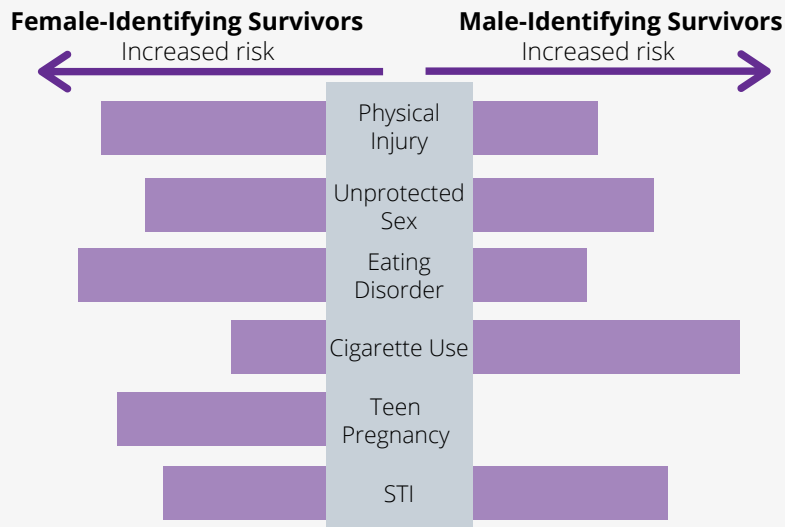
SEXUAL

- any unwanted sexual touch
- exposing genitals
- forcing, coercing or pressuring someone into sexual behaviors or into having oral, anal or vaginal sex
- posting or sharing sexual photos without their partner's permission



C: HEALTH IMPLICATIONS

HEALTH



RESEARCH CLEARLY LINKS TDV AND NEGATIVE LONG-TERM HEALTH OUTCOMES

Injuries sustained from physical violence are only a small part of the long-term health impacts of TDV. Pregnancy and STI may have many downstream health effects. TDV puts patients at greater risk of heart disease, diabetes, and stroke. Sexual assault by an intimate partner further increases these risks.

MENTAL HEALTH

The rate of suicide attempts for females who experienced TDV were 3x the national average

Adult males who were survivors of TDV report increased substance abuse in adulthood

Heavy binge drinking in adult females is correlated with TDV

Anxiety and fewer close friendships were reported in adults who experienced TDV

Adolescence is a time of exploration and forming the self; TDV disrupts this process and may leave an adolescent with low self-worth, low self-esteem, and an increase in drug and alcohol use. Lifelong depression and anxiety can result from these early abusive relationships. Thoughts of suicide are common.



BISEXUAL FEMALES AND TRANS YOUTH HAVE THE HIGHEST RISK FOR DATING VIOLENCE

LGBTQ teens are at high risk of contracting STI, attempting suicide, and being bullied. Those experiences are related to experiencing TDV, as well. Many teens are not "out of the closet" to their families or teachers, so threatening to "out" a partner is a way perpetrators maintain control.



UNSAFE SEXUAL PRACTICES ARE LINKED TO TDV

Unprotected sex, multiple sex partners, sex while under the influence of drugs or alcohol (still able to give consent), accidental pregnancy, and early coitarche (first intercourse before age 14) are associated with TDV.

D: RESPONSE

The presence of a single sign does not prove TDV is occurring in a relationship but a closer examination of the situation may be warranted if more than one sign/symptom occurs often or a few signs/symptoms are presented at once.

ASSESS AS PART OF ROUTINE CARE

New patient visits

Well-child visits

School nurse visits

Emergency care visits

Mental health appointments

Prenatal and postnatal visits



PRACTICE TRAUMA-INFORMED SCREENING

Always review confidentiality limits before screening

Begin with general questions to assess the comfort level

Screen in a private place, away from perpetrator or parent

Use a universal education approach



SUPPORT THE SURVIVOR & HOLD THE OFFENDER ACCOUNTABLE



If it is safe, point out abusive behaviors to the perpetrator: "I notice you're always checking your partner's social media."



Refer the perpetrator to a domestic violence intervention program for an evaluation.



"I'm sorry this is happening to you." Offer to help the patient get connected with resources and help.



Be a good listener. Listen without judgement. Let them know they are not alone.



Remind them that they do not deserve this and they did nothing wrong.

CHAPTER VIII: VULNERABLE POPULATIONS

A: PREVALENCE, SCREENING, COMPLAINTS

Vulnerable populations experience domestic violence in different ways and in varying degrees of intensity based on social categorizations (such as race, class, gender identity, ability, and sexual orientation), which are interconnected and cannot be viewed independently. Some vulnerable populations have a higher prevalence of domestic violence and many face unique barriers to support and healing.

BETWEEN
25% and 35%
OF LGBTQ
INDIVIDUALS ARE
ABUSED BY THEIR
PARTNERS

AN ESTIMATED
13.5%
OF OLDER ADULTS
HAVE SUFFERED
EMOTIONAL ABUSE
SINCE THE AGE OF
60.

50%
OF ADULTS AND
CHILDREN WITH
DISABILITIES
EXPERIENCED
SEXUAL ABUSE OR
ASSAULT ON MORE
THAN 10
OCCASIONS.

48%
OF LATINAS REPORT
THEIR PARTNER'S
VIOLENCE AGAINST
THEM INCREASED
SINCE THEY
IMMIGRATED TO THE
U.S

RACE MATTERS

Race may affect the willingness of survivors to disclose intimate partner violence if there is perceived discordance between provider and patient.

SCREENING

A SURVEY REVEALED THAT
HEALTHCARE PROVIDERS
SCREENED
**65% OF NON-
HISPANIC WHITE
WOMEN FOR DV,**
WHEREAS THEY ONLY SCREENED
**35% OF AFRICAN-
AMERICAN WOMEN.**

Screening tools are often not intersectional; they are not created with regard to the complexity and multifacetedness of DV for survivors, in regard to class and race.



CHIEF COMPLAINT

Domestic violence may be reported differently based on a person's race and/or culture

SOUTH ASIAN

patients are more likely to report

- Gastrointestinal concerns
- Poor physical health
- Chronic/intermittent pain
- Headaches

LATINX

patients are more likely to report

- Bodily Pain
- Headaches
- Back/neck pain



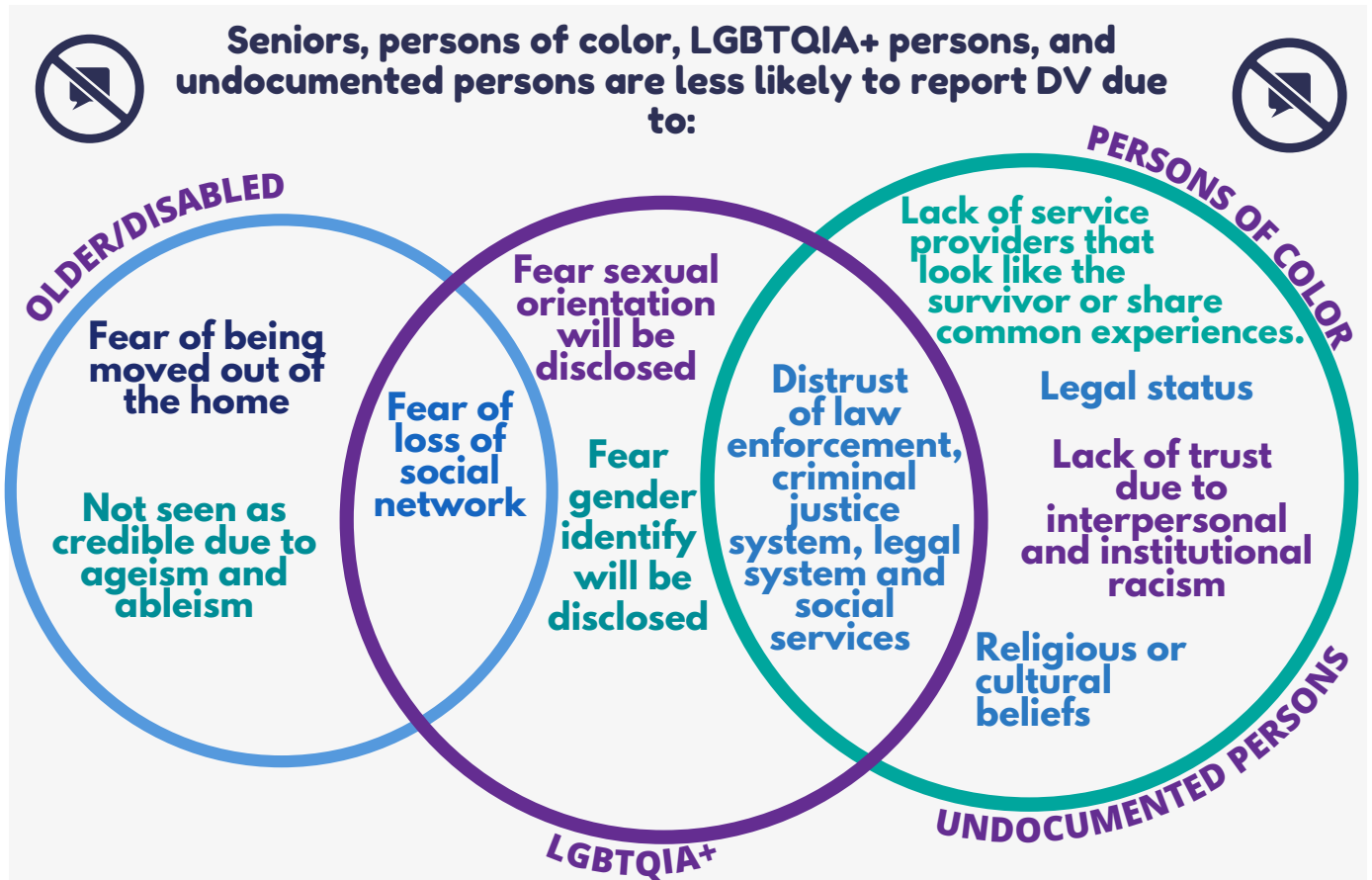
AFRICAN AMERICAN

patients are more likely to report

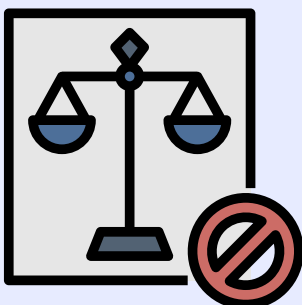
- STI symptoms
- PTSD symptoms
- Eating disorders
- suicidal ideation/attempts

B: BARRIERS AND DISCLOSURES

BARRIERS UNIQUE TO VULNERABLE POPULATIONS



Although the response to LGBTQIA+ survivors of domestic violence is gradually improving, the LGBTQIA+ community is often met with ineffective and victimizing legal responses.



RESPONDING TO A DISCLOSURE

CHAPTER IX: CHILDREN AND DOMESTIC VIOLENCE

A: PREVALENCE AND IMPACT

1 in 15

people are exposed to domestic violence over the course of childhood

1 in 9

children are exposed to physical or psychosocial violence before the age of 18

56.8%

of children exposed to DV were also victims of maltreatment

CHILDREN WHO ARE EXPOSED TO DV MAY HAVE...



A HIGHER RISK OF EXPERIENCING DV AS ADULTS



A HIGHER RISK FOR BEHAVIORAL PROBLEMS



A HIGHER RISK FOR EMOTIONAL ISSUES



A HIGHER RISK FOR LONG TERM HEALTH ISSUES



LOWER GPAS IN SCHOOL



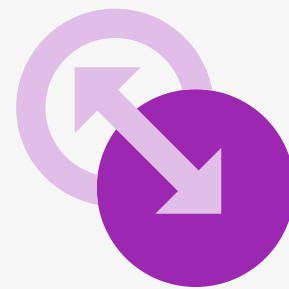
MORE SCHOOL ABSENCES

18% OF CHILD ABUSE REPORTS

accepted for investigation by the Delaware Division of Family Services in FY2019 alleged domestic violence.

33% OF SUBSTANTIATED CASES

in FY2019 stated that domestic violence was reported to the Delaware Division of Family Services during the investigation risk assessment.



In homes with domestic violence between adults, there are greater incidents of physical child abuse. Co-occurrence of DV and child abuse is a common trend.

B: BEHAVIORAL SIGNS AND PROTECTIVE FACTORS

Not all children are affected the same way. Reactions from DV trauma are similar to other trauma stressors. Consider all behavioral signs of abuse in the context of the child's and family's functioning. Supportive environments and people have been shown to mitigate the effects of children's exposure to violence.

BEHAVIORAL SIGNS

BIRTH-AGE 5

- Sleep and/or eating disruptions
- Withdrawal/lack of responsiveness
- Intense separation anxiety
- Inconsolable crying
- Developmental regression or loss of acquired skills
- Intense worries, anxieties or new fears
- Increased aggression and/or impulsive behavior

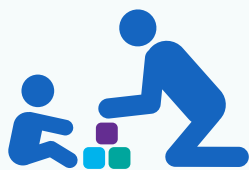
AGES 6-11

- Nightmares and/or sleep disruptions
- Aggression and difficulty with peer relationships at school
- Difficulty with concentration and task completion in school
- Withdrawal and/or emotional numbing
- School avoidance and/or truancy

AGES 12-18

- Antisocial behavior
- School failure
- Impulsive and/or reckless behavior
- School truancy
- Substance abuse
- Running away
- Involvement in violent or abusive dating relationships
- Depression
- Anxiety
- Withdrawal

PROTECTIVE FACTORS



Children do best when they are able to remain with the non-abusive parent



Positive peer and sibling relationships and friendships can buffer the effects of stress and model healthy coping skills



A secure attachment to a non-violent parent or other significant caregiver can mitigate negative consequences of exposure to domestic violence



Presence of supportive non-parent adults such as grandparents can protect the child by acting as agents of social control within the family

C: MANDATORY REPORTING



The presence of domestic violence in the home does not automatically trigger a report to Division of Family Services, unless reportable circumstances are present.



WHEN TO REPORT

Cases of domestic violence involving children must be reported to DFS when a child is experiencing:

PHYSICAL HARM



Child is injured; child is suspected to be injured, since a weapon or potentially dangerous object has been used; or child has attempted to physically intervene.

EMOTIONAL HARM



Child is aware (sight or sound) of an incident perpetrated against his/her caregiver **AND** it involves a significant injury to the victim or use of a weapon; **AND** child has a diagnosed mental health condition or behaviors that signify severe psychological harm.

FACTORS THAT INFLUENCE LEVEL OF SUSPICION



**KNOWLEDGE
OF THE
SITUATION**



**KNOWLEDGE
OF THE
FAMILY**



**CHILD'S
HISTORY &
SITUATION**



**HEALTHCARE
PROVIDER'S OWN
THRESHOLD OF
SUSPICION**



**FAITH IN THE
CHILD
PROTECTION
SYSTEM**

Should a provider become aware of a reportable circumstance, healthcare providers do well to remember that their **first commitment is to their patients** and their rights and welfare and thereby **adapt and tailor their responses** to facilitate the provision of the **best possible care** to each individual patient, **within the confines of the law**.

D: ASSESSMENTS AND DISCLOSURES

The presence of a single sign does not prove domestic violence is occurring in a family but a closer examination of the situation may be warranted if more than one sign/symptom occurs often or a few signs/symptoms are presented at once.

ASSESS AS PART OF ROUTINE CARE

Newborn visits

New patient visits

Well-child visits

Mental health appointments

Emergency care visits

Prenatal and postnatal visits



PRACTICE TRAUMA-INFORMED SCREENING

Always review confidentiality limits before screening

Begin with general questions to assess comfort level

Screen in a private place, away from a potential abuser

Use a universal education approach



RESPONDING TO DISCLOSURES AND REPORTING

Believe any disclosure!

Show support and concern.

Let the child, adolescent, or caregiver know they did the right thing.

Reassure them they are not alone and help is available.

"I'm so sorry that happened to you. It's not your fault."

"Thank you for letting me know. I know it was hard, but you did the right thing."

"I'm worried about your safety. Can I connect you with some resources?"

"You are not alone in this. There are many people that can help you."

If you must make a report, let the non-offending parent know.

Follow trauma-informed reporting guidelines.

You might have strong feelings before, during, and after reporting. Take care of yourself.

CHAPTER X: ELDER ABUSE

A: RISK FACTORS, SIGNS AND SCREENING

Older patients experiencing domestic violence may present with different symptoms and risk factors. Professionals working with older adults must be mindful of the role that ageism can play in how older individuals may be perceived and treated when they experience abuse. Understanding ageism and avoiding judgment around an older adult's choices are critical components of providing effective support.

RISK FACTORS

Persons who are abused in later life often experience shame, guilt, or other adverse emotions. These emotions can be compounded if the perpetrator is their own child or another relative. For these reasons, older survivors may not wish to end the relationship with their abuser, instead they may want to protect the abuser and hide the abuse.

- Perpetrator is most likely to be an adult child or intimate partner
- Perpetrator is dependent on elder
- Elder is dependent on perpetrator
- Low social support
- Dementia
- Functional impairments and poor physical health
- Isolation of abuser-elder dyad

POSSIBLE SIGNS OF ABUSE



Improperly administered medication



Missed appointments despite access to care



Unable to meet with patient alone



Broken eyeglasses



Falls with unconvincing story



Suspicious changes in ability to pay

SCREENING TOOLS

1. VULNERABILITY TO ABUSE SCREENING SCALE (VASS)
2. HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST (H-S/EAST)
3. ELDER ABUSE SUSPICION INDEX (EASI)

CHAPTER XI: HUMAN TRAFFICKING

A: PREVALENCE AND BARRIERS

WHAT IS HUMAN TRAFFICKING?

Human trafficking is the exploitation of someone for the purposes of compelled labor or commercial sex acts through the use of **force, fraud, or coercion**.

WHO IS A TRAFFICKED PERSON?

A person may be unaware that their situation is considered trafficking. Traffickers prey on all ages, gender identities, races, sexual orientations, socioeconomic groups, and immigration statuses. **A trafficker need not control every aspect of a person's life in order to exploit them.**

87.8% of trafficking survivors reported accessing healthcare services during their trafficking situation.

68.3% of them were seen at an emergency department

IT IS NOT UNCOMMON IN FEDERAL TRAFFICKING PROSECUTIONS FOR THE TRAFFICKER TO BE THE ROMANTIC PARTNER OF THE VICTIM.



WHEN DO SURVIVORS SEEK MEDICAL SERVICES?

- 1.** For routine checkups
- 2.** For pre-existing conditions unrelated to trafficking
- 3.** For mental health services or addiction treatment
- 4.** For gynecological services/prenatal care
- 5.** In an emergency/after an assault

BARRIERS TO SELF-IDENTIFICATION

SHAME OR GUILT

TRAUMA BONDING/
ATTACHMENT

LACK OF
TRANSPORTATION
OR LEGAL
DOCUMENTS

TRAFFICKER COULD
WITHOLD DRUGS,
FOOD, SHELTER,
MONEY

FEAR OF
DEPORTATION

FEAR OF
PROSECUTION FOR
CRIMES COMMITTED
WHILE TRAFFICKED

FEAR OF LOSING
CUSTODY OF
CHILDREN

LACK OF
UNDERSTANDING OF
U.S. HEALTHCARE
SYSTEM

IT IS THE SAFEST
OPTION AT THE
TIME

PAST FAILURE OF
THE SYSTEM TO
RESPOND

B: RECOGNIZING THE INDICATORS

WHO MIGHT RECOGNIZE A TRAFFICKED PERSON?

Anyone in the healthcare system may have the opportunity to recognize a trafficked person. The following is a list of possible access points

- ✓ Ambulatory care
- ✓ Emergency department
- ✓ Customer service staff
- ✓ Physicians & surgeons
- ✓ Nursing staff
- ✓ Social workers
- ✓ Plastic surgery practices
- ✓ Ophthalmologists
- ✓ Community health workers
- ✓ Sexual assault response teams (SART)
- ✓ Therapists
- ✓ Dental offices
- ✓ Psychiatric units
- ✓ Substance use treatment programs
- ✓ Health educators
- ✓ Interpreters
- ✓ Lab technicians
- ✓ Support staff
- ✓ Housekeeping/environmental services

HEALTH INDICATORS OF TRAFFICKING

PHYSICAL

Multiple or recurrent STIs

High number of sexual partners

Trauma to vagina and/or rectum

Suspicious workplace injuries

Signs of physical trauma or neglect

Somatization symptoms

Suspicious tattoos or branding

BEHAVIORAL

Depressed mood/Flat affect

Anxiety/Hyper-vigilance/Panic

Affect dysregulation/Irritability

Frequent emergency care visits

Unexplained/Conflicting stories

Lacks ID or documents with name

Signs of drug or alcohol abuse

C: ASSESSMENT AND REFERRAL

SIMILARITIES BETWEEN IPV AND HUMAN TRAFFICKING SURVIVORS	DOMESTIC VIOLENCE	HUMAN TRAFFICKING
PHYSICAL AND SEXUAL VIOLENCE	✓	✓
RESTRICTIONS ON FREEDOM OF MOVEMENT/ CONTROL	✓	✓
ISOLATION	✓	✓
FINANCIAL CONTROL	✓	✓
INTIMIDATION, FEAR	✓	✓
COERCING DRUG AND ALCOHOL DEPENDENCIES	✓	✓

IF YOU'RE NOT SURE IF YOUR PATIENT IS EXPERIENCING DOMESTIC VIOLENCE OR HUMAN TRAFFICKING, OFFERING EITHER RESOURCE IS APPROPRIATE.

THE PATIENT KNOWS WHAT ACTION, IF ANY, IS SAFEST.



INITIAL ASSESSMENTS

- 1 CONDUCT ASSESSMENTS INDIVIDUALLY, IN A SAFE LOCATION
- 2 ASSESS THE PATIENT'S IMMEDIATE SAFETY
- 3 USE LANGUAGE UNDERSTANDABLE TO THE PATIENT
- 4 DO NOT ASK FOR UNNECESSARY INFORMATION

MEDICAL ASSESSMENT TOOLS:

- 1 MEDICAL ASSESSMENT FLOW CHART
- 2 WHAT TO LOOK FOR DURING A MEDICAL EXAM
- 3 NHTRC COMPREHENSIVE ASSESSMENT

NATIONAL HUMAN TRAFFICKING HOTLINE

1-888-373-7888

CONFIDENTIAL | 24/7 | TOLL-FREE
(INTERPRETERS AVAILABLE)

NHTRC@POLARISPROJECT.ORG
WWW.TRAFFICKINGRESOURCECENTER.ORG

CHAPTER XII: SUBSTANCE USE COERCION

The active use of substance use issues against a partner as a tactic of control.

Among people who experience DV, substance use is **2 - 6x higher**

47% - 90% of women in SUD treatment have experienced DV in their lifetime

90% of women attending a methadone clinic experienced DV

60% of participants in the Substance Abuse Coercion Study report their partners had tried to interfere with their treatment

SUBSTANCE USE COERCION MECHANISMS OF CONTROL



INTRODUCING PARTNER TO DRUGS AND/OR ALCOHOL; FORCING USE



FORCING PARTNER INTO WITHDRAWAL; USING ADDICTION TO CONTROL



COERCING PARTNER TO ENGAGE IN ILLEGAL ACTS



USING SUBSTANCE USE HISTORY AS A THREAT



ISOLATING PARTNER FROM RECOVERY RESOURCES



SABOTAGING RECOVERY EFFORTS; TREATMENT INTERFERENCE

TALKING ABOUT SUBSTANCE USE COERCION

Create a safe space.

Discuss Substance Use Coercion as part of your conversations about DV.

Incorporate into a Substance Use history.

"Sometimes, people who are being hurt by someone in their life or have been hurt in the past, use alcohol or other drugs to help them cope. Do you ever use alcohol or drugs to numb the effects of abuse?"

"Has your partner ever made you use alcohol or other drugs, made you use more than you wanted, or threatened to harm you if you didn't? Has your partner ever tried to stop you from cutting down on your drinking or drug use?"

"It is never your fault when someone harms you if you are drinking or using. You deserve to be treated with dignity and respect."

"Your partner might find other people to agree that your substance use gives them a right to control or abuse you. Undermining your credibility with other people makes it difficult for you to get support, be believed, and trust your own perceptions."

Strategize safe ways to access treatment and services.

Discuss coping strategies and emotional safety.

Ask specifics about coercion during substance use assessments and screenings.

CHAPTER XIII: MENTAL HEALTH COERCION

The active use of mental health issues against a partner as a tactic of control.

Individuals experiencing any type of DV are nearly

3x

more likely to report symptoms of severe depression

50%

of individuals experiencing DV say that their partner threatened to report their MH to limit things they wanted/needed

90%

of women hospitalized post-suicide attempt reported current, severe DV

MENTAL HEALTH COERCION MECHANISMS OF CONTROL



CONTROL OF MEDICATIONS: WITHHOLDING, & COERCING TO TAKE



GASLIGHTING: TWISTING SITUATIONS TO MAKE THE PATIENT LOOK OR FEEL CRAZY



THREATEN TO REPORT MENTAL HEALTH TO INFLUENCE CUSTODY HEARINGS



CONTINUOUSLY "DIAGNOSING" THE PATIENT; UNDERMINING THE PATIENT'S SENSE OF SANITY



TELLING FRIENDS/FAMILY THAT THE PATIENT IS UNSTABLE



USING MENTAL HEALTH DIAGNOSES TO MAKE FALSE ALLEGATIONS

TALKING ABOUT MENTAL HEALTH COERCION

Create a safe space.

Discuss Mental Health Coercion as part of your conversations about DV.

Validate perceptions, acknowledge impact, express concern

"Does your partner tell you that you are lazy, stupid, 'crazy,' or a bad parent because of your mental health condition? That no one will believe you because of your mental health condition?"

"Has your partner ever tried to prevent or discourage you from accessing mental health treatment or taking your prescription medication? Prevent you from eating or sleeping?"

"Even if you have had many hospitalizations, or used medication for years, you have the same right to safety and dignity as anyone else."

"What are some of the ways you cope? What do you find works the best? What are the strengths and supports you draw on?"

Strategize safe ways to access treatment and services.

Document efforts to protect and care for children.

Provide "warm referrals" to community DV resources

CHAPTER XIV: CONFIDENTIALITY

Critical to any healthcare response is confidentiality. When it comes to confidentiality and a patient's electronic health records, patients impacted by domestic violence have unique needs. Inappropriate disclosure of information concerning domestic violence may endanger or further victimize patients. It is important for healthcare providers to understand when information shared by a patient will remain privileged and confidential; limits of confidentiality; mandatory reporting; who else might have access to a patient's electronic medical record and health data; how to safely document domestic violence in an electronic health record (EHR); and the potential consequences of any breach of confidentiality to medical records.

Because a breach of confidentiality could result in serious – and sometimes lethal – safety consequences, healthcare providers must be vigilant in understanding and practicing confidentiality best practices.



24-HOUR DOMESTIC VIOLENCE HOTLINES

(302) 762-6110 : New Castle

(302) 244-8058 : Kent

(302) 678-3886 : Sussex

(302) 745-9873 : Bi-lingual

**ADDITIONAL RESOURCES CAN BE FOUND AT
THE END OF THIS MANUAL**

A: ELECTRONIC HEALTH RECORD (EHR)

It is vital that information related to domestic violence is kept confidential to protect patients from further harm, injury or death. When sharing information about adult patients, disclosure must be based on consent, unless mandated. Consents and release of information forms are the most common mechanism for tracking who, besides a patient, health information can be shared with. However, there are other, less obvious avenues for confidentiality breaches that healthcare providers should be aware of.

TREATMENT OF OTHER FAMILY MEMBERS

Healthcare providers should be particularly careful in situations where confidentiality could accidentally be broken and cause harm, such as, in general practice, where health professionals might treat other members of a patient's family - including the perpetrator of the domestic violence. Some perpetrators use providers as a source of information to track down a patient (i.e., to obtain a patient's address, contact information, or phone number). Exercise discretion when treating a child with known domestic violence in the home (i.e. take care that records on display do not include a contact address or any other confidential information).

SHARED ELECTRONIC HEALTH RECORD

While EHR are beneficial in many ways, for patients impacted by domestic violence, shared access to EHR may have the potential to pose safety and confidentiality concerns. In Delaware, many EHR can be accessed by a range of providers. For example, when a hospital is affiliated with PCPs and specialists in the area, providers in any affiliated setting can have access to a patient's EHR. Providers should be mindful of who currently accesses, or has opportunities to access, patient's medical information, when said patient has disclosed or discussed domestic violence.

BEST PRACTICE TIP: A patient discloses current abuse to their HCP—but shares that the abuser is a provider in the same health system who has access to all patients EHRs, including theirs. The provider should enable protections on the patient's personal information, so that all external viewing of the patient's data is prohibited.

National Health Resource Center on Domestic Violence. (2013). Considerations for Explanation of Benefits. Retrieved from Futures Without Violence:
<https://ipvhealthpartners.org/prepare/>



DISCHARGE PAPERWORK

Be mindful when providing discharge paperwork, after-visit summaries, and/or referrals which may contain confidential information or details about the medical encounter. Consider speaking to the patient about who has access to discharge paperwork and offer other options for follow-up and referrals. **Never give discharge paperwork or resources unless it is safe to do so.**

EXPLANATION OF BENEFITS

Explanation of Benefits are one way that a patient's abuser could learn that your patient has received treatment for, or has discussed, domestic violence with a provider. EOBs are triggered when a provider submits a claim to the insurance company. Providers should be aware of how EOBs may impact their patients, especially when the abuser is also the insurance policyholder.

EOB CONCERNS AND CONSIDERATIONS:

- Patients impacted include:
 - Adult spouses who are not the policyholder.
 - Young adults to age 26 who get their health insurance through their parents' plan.
 - Minors who want to access health services they are allowed to access without their parents knowing and/or without parental consent (i.e reproductive and mental health).
- EOBs are sent to policy holders, not to the patient. This means that the policyholder will have access to information detailing services provided to a patient.
- Sensitive data may be shared on EOBs. This could include the name or type of provider (e.g., a counselor or an STI clinic); the type of services delivered; or any other information that the patient does not intend to share with the policyholder.
- This troubling disclosure of information impacts a wide range of patients but has a disproportionate impact on vulnerable patients who do not want to share their personal health information, or wish to control who can see their data and when.

Adapted from National Health Resource Center on Domestic Violence. (2013). Considerations for Explanation of Benefits. Retrieved from Futures Without Violence: <https://ipvhealthpartners.org/prepare/>

B: SOLUTIONS AND PRINCIPLES

Providers must always remember it is the patient's information. The patient retains the right to choose when, what, and how personal information will be shared, or not shared, and with whom. Healthcare providers and staff are responsible for respecting and honoring the patient's wishes and safeguarding any of the patient's information that they collect or hold. Developed by the National Health Resource Center on Domestic Violence and Futures Without Violence, the following are best practices surrounding the use and disclosure of health information.



Health Information Technology and Health Information Exchange: Privacy Principles for Protecting Victims of Domestic Violence September 2013

Policy and practice surrounding the use and disclosure of health information—on paper or electronic—should respect patient autonomy and confidentiality while trying to improve the safety and health status of a patient. There should be strong and enforceable penalties for failure to comply with privacy rules and regulations.

1. Personal and sensitive health information should be de-identified whenever possible
2. Educate patients about the limits of confidentiality, what EOBs are, and what may happen
3. Individuals should have the right to access, correct, amend, and supplement their own health information
4. Individuals should receive notice of how health information is used and disclosed, including specific notification of the limits of confidentiality
5. Providers must offer and respect patient's choice of communication preferences, including by phone, email, etc., and under what circumstances
6. Privacy safeguards and consents should follow the data
7. Providers should have broad discretion to withhold information when disclosure could harm the patient
8. Providers and administrators should work together to ensure that any patient summaries or explanation of benefits do not include sensitive information, such as Ecodes or ICD10 codes, and should consult with patient about what is safe to document
9. There should be strong and enforceable penalties for violations of privacy and consents both in a clinical setting, and across information exchanges

(National Health Resource Center on Domestic Violence)

C: LAW ENFORCEMENT AND CONFIDENTIALITY

The chart below summarizes some of the common situations when law enforcement (LE) may access health information without patient consent under Health Insurance Portability and Accountability Act (HIPAA) regulations. Additionally, healthcare providers may be required by law to report certain injuries to LE, as discussed in the Legal Mandates chapter of this manual. Do not assume that law enforcement is a safe option for all.

SCENARIO	WHAT MAY BE DISCLOSED	LIMITATIONS ON WHAT MAY BE DISCLOSED
Healthcare provider receives court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or grand jury subpoena	Information authorized by the court order, court-ordered warrant, subpoena, or summons	Provider must limit the disclosure to the scope of the court order, warrant, subpoena, or summons
Provider receives administrative subpoena, summons, investigative demand, or other non-judicial process authorized by law	Information authorized by the administrative demand	LE must certify that the information requested is relevant, material, specific, and limited in scope, and that de-identified information could not reasonably be used
LE asks about a patient by name	The patient's location in the healthcare facility and general medical condition	Information must not be released if the patient has opted out
LE requests information to identify or locate a suspect, fugitive, witness, or missing person	Name; address; birth date; SSN; blood type; injury; date and time of treatment; date and time of death; physical description	Provider cannot disclose information related to the patient's DNA; dental records; samples of or analysis of body fluids or tissue
LE requests information about a crime victim who cannot consent due to incapacity or emergency	Information that LE states is needed to determine whether a crime has occurred	Information cannot be intended to be used against the survivor; LE's need must be immediate; disclosure must be in the survivor's best interests

CHAPTER XV: DOCUMENTATION

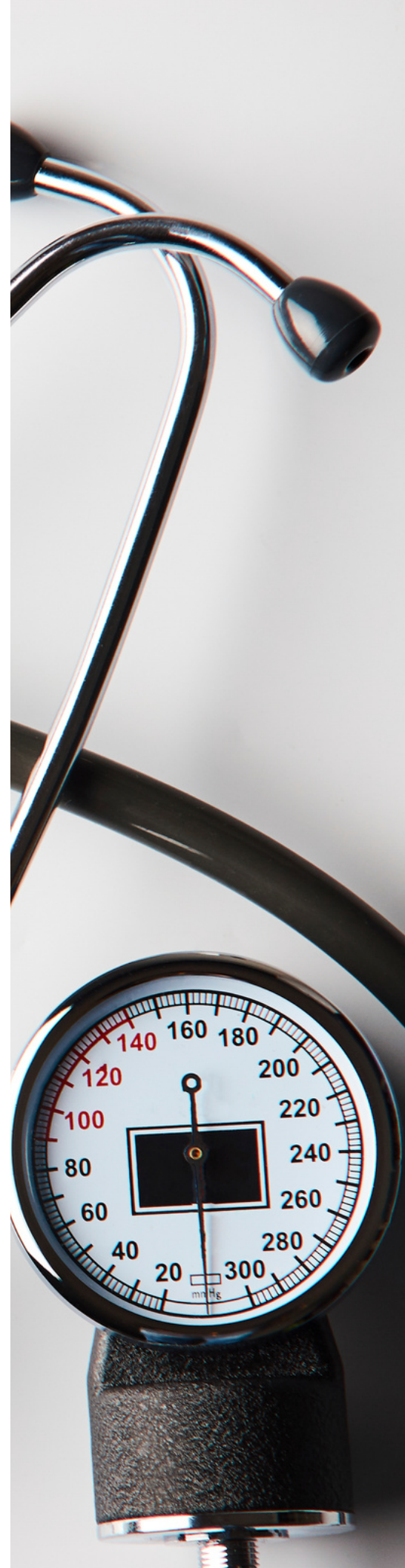
Well-documented medical records are essential. They prompt appropriate referrals for mental health treatment and services. Additionally, they increase the effective and necessary coordination of care between providers. Moreover, they provide concrete evidence of violence and abuse and may prove to be 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. At the same time, health records – if disclosed to a perpetrator either accidentally, or through an explanation of benefits – could have dire consequences for a patient. This chapter will focus on documentation practices for general health provider and non-forensic experts.

Medical providers are encouraged to consider their professional ethics and organizational policies, when making decisions about the privacy of patients, (i.e., documentation and information sharing with other providers). The decision to document disclosures of domestic violence should be carefully considered.

BEFORE YOU DOCUMENT:

- 1. Consider your patient's safety as a paramount issue. Your patient is the expert on their safety and what is safe for them.**
- 2. Educate your patient about limits of confidentiality and the function of EOBs.**
- 3. Ask your patient what is safe to include in the EHR and invite your patient to review and/or edit their EHR.**
- 4. Ask your patient who has access or opportunities to access their medical information and implement viewing restrictions, if necessary.**

[1] Forensic doctors, Sexual Assault Nurse Evaluators (SANE) and forensic examiners have different roles which are discussed in the Sexual Assault chapter of this manual.



ELEMENTS OF A WELL-DOCUMENTED MEDICAL RECORD:

1. 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.
2. Avoid any subjective interpretation of events or data.
3. Chief complaint and description of the abusive event should use the patient's own words whenever possible rather than the physician's assessment. "My partner hit me with a bat" is preferable to "Patient has been abused." Use quotations when documenting the patient's description of abuse.
4. Consider taking photographs of injuries. If photo documentation is applicable and permissible, the HCP should ask or refer to a Forensic Nurse for assistance when possible.

CPT AND ICD-10 CODES

As previously mentioned, Explanations of Benefit statements and patient billing statements have the potential to inform perpetrators that a patient has disclosed or discussed domestic violence with their healthcare provider. The disclosure of this information may lead to retaliation against a patient, increased risk of harm, or lethality. On the other hand, when domestic violence is detected, an electronic health record can prompt providers to the correct referrals, counseling, and services to ensure that patients get the help they need (National Health Resource Center on Domestic Violence). In order to reduce harms, best practice encourages providers and administrators to work together to ensure patient summaries and EOBs exclude sensitive information (i.e. diagnostic or external cause codes), which may indicate screening, assessment, or referral for domestic violence during an encounter. **Additionally, providers should inquire with their patient about what information is safe to document.**

DID YOU KNOW: Preventive Medicine Service codes include age appropriate counseling/anticipatory guidance/risk factor reduction interventions. These codes can accurately be used for encounters for DV.

Best Practice TIPS:

- Consider your patient's safety as a paramount issue.
- Your patient is the expert on their safety and what is safe for them.
- Ask your patient who has access or opportunities to access their medical information.



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**Special thanks
to our local
partners**



**DELAWARE SEXUAL ASSAULT
NURSE EXAMINERS**



AND MORE!

Quick Reference Resource Page

Domestic Violence & Sexual Assault 24 Hour Hotlines

Statewide

YWCA Sexual Assault Response Center 24-Hour Hotline

1-800-773-8570

ContactLifeline 24-Hour Crisis Line
1-800-262-9800

New Castle County

24-Hour Domestic Violence Hotline
302-762-6110

Kent & Sussex Counties

302-422-8058 / 302-678-3886

Bi-Lingual Hotline
302-745-9874

National Resources

Teen Dating Abuse Hotline
1-866-331-9474

National DV Hotline
1-800-799-7233

National DV Hotline TTY
1-800-787-3224

National Human Trafficking Hotline
1-888-373-7888

Suicide Prevention Hotline
1-800-273-TALK (8255)



If you are in danger,
please call 911

DVCC & Domestic Violence Advocates

DVCC Main Office

Phone: 302-255-1700

DVCC_Information@delaware.gov

DVCC Kent & Sussex County Office

Phone: 302-424-7238

Fax: 302-424-5311

Domestic Violence Community Health Advocates

302-757-2137

(New Castle County)

Other Delaware Resources

Delaware Legal Help Link

1-888-225-0582

Court-Based
Advocacy Services
302-255-0420

24/7 Delaware
Victim Center
1-800-842-8461

Adult Victim Services
(50+)
302-658-7174

Adult Protective
Services
1-800-223-9074

Child Abuse Report
Line
1-800-292-9582

Division of Long-Term
Care Residents
Protection
1-877-453-0012

DOJ Senior
Protection Initiative
New Castle County:
302-577-8600

Kent County:
302-739-7641

Sussex County:
302-856-5353

Toll Free Consumer
Hotline
1-800-220-5424

Para asistencia en
Español
1-877-851-0482

Delaware Resources

Domestic Violence & Sexual Assault 24 Hour Hotlines

Statewide

YWCA Sexual Assault Response Center

24-Hour Hotline

1-800-773-8570

Contact Lifeline 24-Hour Crisis Line

1-800-262-9800

New Castle County

24-Hour Domestic Violence Hotline

302-762-6110

Kent & Sussex Counties

302-422-8058 / 302-678-3886

Bi-Lingual Hotline

302-745-9874

Legal Resources

Community Legal Aid Society (CLASI)

NCC: 302-575-0660

Kent: 302-674-8500

Sussex: 302-856-0038

Delaware Legal Help Link

1-888-225-0582

Court-Based Advocacy Services

302-255-0420

Other Delaware Resources

Crisis Text Line for Youth

Text DE to 741-741

The Beau Biden Foundation

(302) 477-2018

DVCC & Domestic Violence Advocates

DVCC Main Office

Phone: 255-1700

DVCC Kent & Sussex County Office

Phone: 302-424-7238

Fax: 302-424-5311

Domestic Violence Community Health Advocates

302-757-2137

(New Castle County)

Other Delaware Resources

24/7 Delaware Victim Center

1-800-842-8461

Delaware Center for Justice Adult Victim Services Program

302-658-7174

Adult Victim Services (50+)

302-658-7174

Adult Protective Services

1-800-223-9074

Child Abuse Report Line

1-800-292-9582

Division of Long-Term Care Residents Protection

1-877-453-0012

DOJ Senior Protection Initiative

New Castle County:
302-577-8600

Kent County:
302-739-7641

Sussex County:
302-856-5353

Toll Free Consumer Hotline
1-800-220-5424

Para asistencia en Español
1-877-851-0482

Delaware Resources

Sexual Assault Nurse Examiners (S.A.N.E.) Units

New Castle County

**Nemours/A.I. DuPont Hospital for
Children**

302-651-6901

Christiana Hospital

302-733-4799

Kent County

Bayhealth/Kent General Hospital

302-744-6308

Sussex County

Nanticoke Memorial Hospital

302-629-6611 ext. 3910

**Beebe Healthcare Walk-in Care
(Rehoboth and Georgetown
Locations)**

302-645-3311

University Victim Advocacy Services

**University of Delaware Sexual
Offense Support (SOS)**

302-831-1001

**Delaware State University
24-hour Rape Crisis Line**

302.420.5751

Helpful Links

**School Based Health Centers (Wellness
Centers)**

To find a school based health center visit
[https://www.dhss.delaware.gov/dhss/dph/
chca/dphsbhcceninfo01.html](https://www.dhss.delaware.gov/dhss/dph/chca/dphsbhcceninfo01.html)

[Mandatory Reporting and Community
Resources Handout](#)

[Mandated Reporter Resource Guide](#)

[Spanish Mandated Reporter Resource
Guide](#)

[Mandatory Reporting Flow Chart](#)

National Resources

Human Trafficking Hotline
1-888-373-7888

LGBTQ National hotline
888-843-4564

Trans Lifeline
877-565-8860

Trevor Project LGBTQ Lifeline
1-866-488-7386
Text: START to 678-678

24 Teen Dating Violence Hotline
1-866-331-9474
Text: LOVEIS to 22522

SafeAndRespectful.org