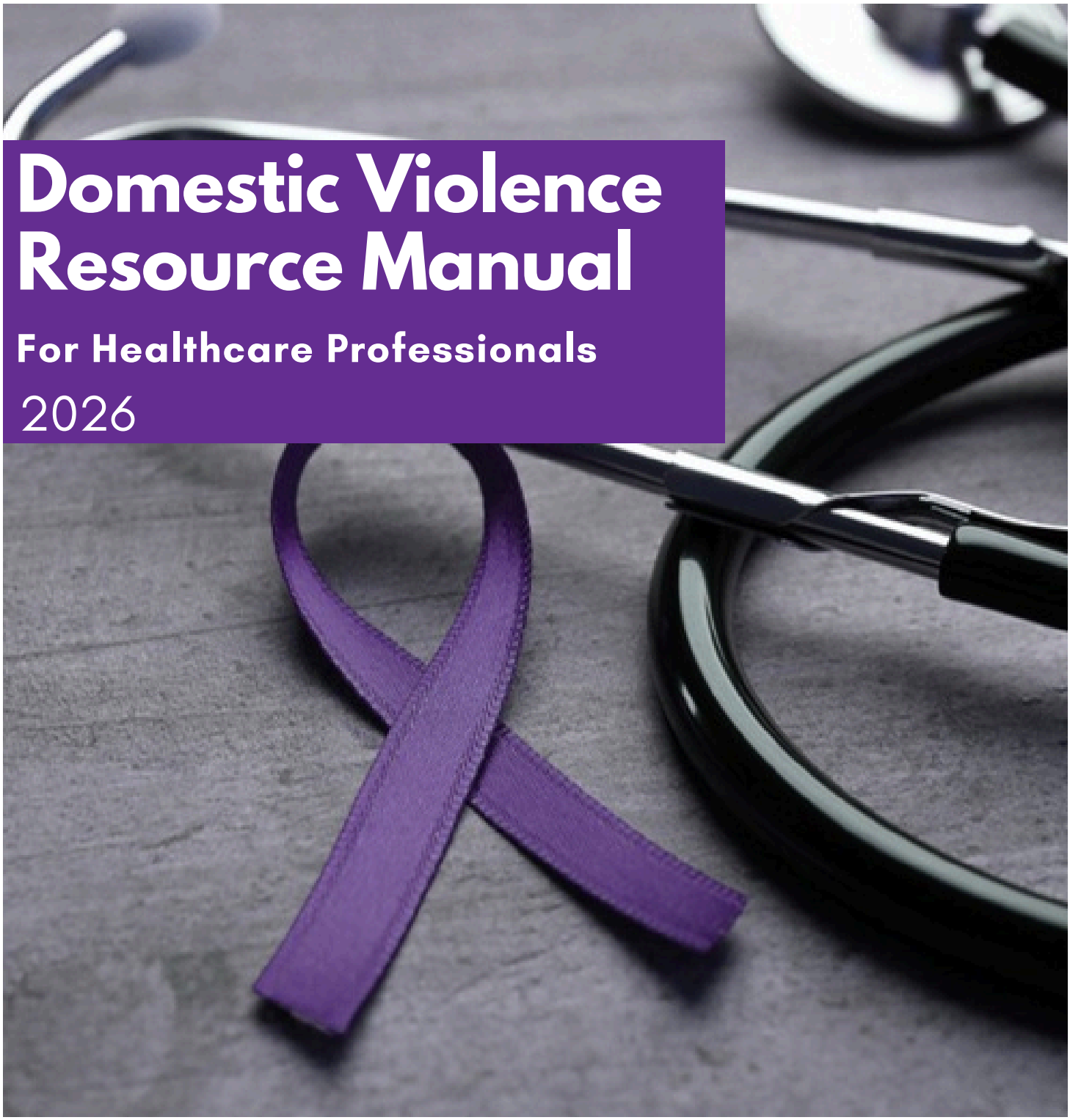

Domestic Violence Resource Manual

For Healthcare Professionals

2026

Provided by Delaware's

Domestic Violence Coordinating Council

www.dvcc.delaware.gov

Quick Reference Resource Page

Domestic Violence & Sexual Assault 24 Hour Hotlines

Sexual Assault - Statewide

YWCA Sexual Assault Response Center

24-Hour Hotline

1-800-773-8570

ContactLifeline 24-Hour Crisis Line

1-800-262-9800

DV - New Castle County

24-Hour Domestic Violence Hotline & Bi-lingual Spanish

302-762-6110

DV - Kent & Sussex Counties

24-Hour Domestic Violence Hotline

302-422-8058 / 302-678-3886

Bi-lingual Spanish 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

Domestic Violence Community Health Advocates

New Castle County

302-757-2137

Kent & Sussex Counties

302-422-8058

Other Delaware Victim Resources

DVCC's Resource Page is updated regularly and contains many other important services for survivors. Scan qr code.

Reporting Resources

24/7 Victim Center & Police-Based Victim Services
1-800-VICTIM-1
1-800-842-8461

Child Abuse Reporting
1-800-292-9582

Animal Abuse Reporting
Delaware Animal Services (Statewide)
302-255-4646

City of Newark
302-366-7111

City of Dover
302-736-7111

Adult Protective Services
1-800-223-9074

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

DOJ Senior Protection Initiative Email:
seniorprotection@delaware.gov

DOJ Victim/Witness Assistance Program
New Castle County:
302-577-8500

Kent County
302-257-3293

Sussex County
302-752-3263

Para asistencia en Español
1-877-851-0482

MESSAGE FROM THE CHAIR

This manual is an update to the DVCC Resource Manual for Healthcare Professionals, 2021. At the time of its initial release, healthcare providers were advised of changes in domestic violence care pertinent to the Affordable Care Act. Consequently, we have experienced multiple transitions in the practice environment, from the COVID 19 pandemic to turnovers in political climate and resulting shifts in healthcare, immigration and overall policy. These changes have 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 and the systems in which they practice. Some individuals may be comfortable within their own area of expertise but less comfortable outside of it. To that end, this committee has endeavored to make this manual available either physically or electronically in all healthcare settings to help any provider with screening and responding to a disclosure. Mandatory reporting requirements are provided so that the provider is equipped with knowledge on how to respond in a way that preserves the patient's autonomy and safety. We do caution that the patient is ultimately the expert on the violence they experience and an unmandated and undesired report to police or other authorities may potentially 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 also in consideration of overlapping circumstances. It may, for instance be initially unclear 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.

With gratitude, we acknowledge the members of the Medical Committee, Children and DV Committee, and staff and interns of the Domestic Violence Coordinating Council for their invaluable contributions to this manual.

Josephine Mokonogho, MD
Chair, Medical Committee
Domestic Violence Coordinating Council

This resource manual was developed and approved by the Domestic Violence Coordinating Council.

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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).[6]

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.[3] 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.[4] 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.[5] 34.6% transgender individuals report physical abuse by a partner at some point in their lives and 64% report experiencing sexual assault.[5] In the State of Delaware, between July 1, 2024 and June 30 2025, there were 25,625 combined criminal and non-criminal domestic violence incidents reported. Of the 10,787 criminal incidents reported, 22% resulted in physical injury to the victim.[2]

1 in 3

women experience intimate partner violence, most before age 25 [3]

1 in 7

men experience severe physical abuse by an intimate partner[3]

34.6%

of transgender individuals report experiencing physical abuse in their lifetime[5]

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[4]

2 in 5

teenagers have been victims of assault, bullying, and/or teen dating violence[4]

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

This research concluded with a critical call for hospital-based IPV intervention programs as a priority for trauma centers to adopt.[1]

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.

FAMILY 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 income 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, coerced debt and reducing or denying access to finances, medical insurance or personal documents. 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: RISK FACTORS

Risk factors are not direct root causes but are dynamics or contributing factors that can increase the likelihood of experiencing or perpetrating domestic violence.

Individual

- Economic stress
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression and suicide attempts
- Lack of problem-solving skills
- Isolation
- Emotional dependence and insecurity
- Desire for power and control in relationships
- Hostility towards women
- Attitudes accepting or justifying violence
- History of physical or emotional abuse in childhood
- Limited social support

Relationship

- Relationship conflicts including jealousy, possessiveness, tension, divorce, or separations
- Dominance and control of the relationship by one partner over the other
- Families experiencing economic stress
- Association with antisocial and aggressive peers
- Parents with less than a high school education
- Witnessing violence between parents as a child
- History of experiencing physical discipline as a child

Community/Society

- High rates of poverty and limited educational and economic opportunities
- High unemployment rates
- High rates of violence and crime
- Low community involvement among residents
- Easy access to drugs and alcohol
- Weak community sanctions against intimate partner violence
- Cultural norms that support aggression toward others
- Income inequality
- Weak health, educational, economic, and social policies or laws

E: ANIMAL ABUSE & IPV

There is over 40 years of research that has established significant links between:

- ✓ **Animal Abuse**
- ✓ **Domestic Violence**
- ✓ **Child Abuse & Neglect**
- ✓ **Elder Abuse**
- ✓ **Lethal Violence toward Police**
- ✓ **Mass Shootings**

The LINK

Abuse of animals is often an indicator or predictor crime and a "red flag" warning sign that other family members in the household may not be safe.

When victims of IPV seek a protective order, they must list and describe the types of abuse that have taken place. Abuse of a companion animal, or threats or intimidation to exploit the close bond with the animal, can be included. The petitioner may also request exclusive care, custody and control of the animal(s). (10 Del. C. §1041 & §1045)

Consistently, studies show that half of pet-owning DV victims delayed leaving, did not leave or would not leave the abusive relationship because of concern for the pet(s).[3]

Three quarters of children exposed to animal cruelty also reported experiencing child abuse.[2]

89% of women in DV shelters who owned animals reported that their pets had been abused by the perpetrator.[1]

When animals are abused, people are at risk.
When people are abused, animals are at risk.

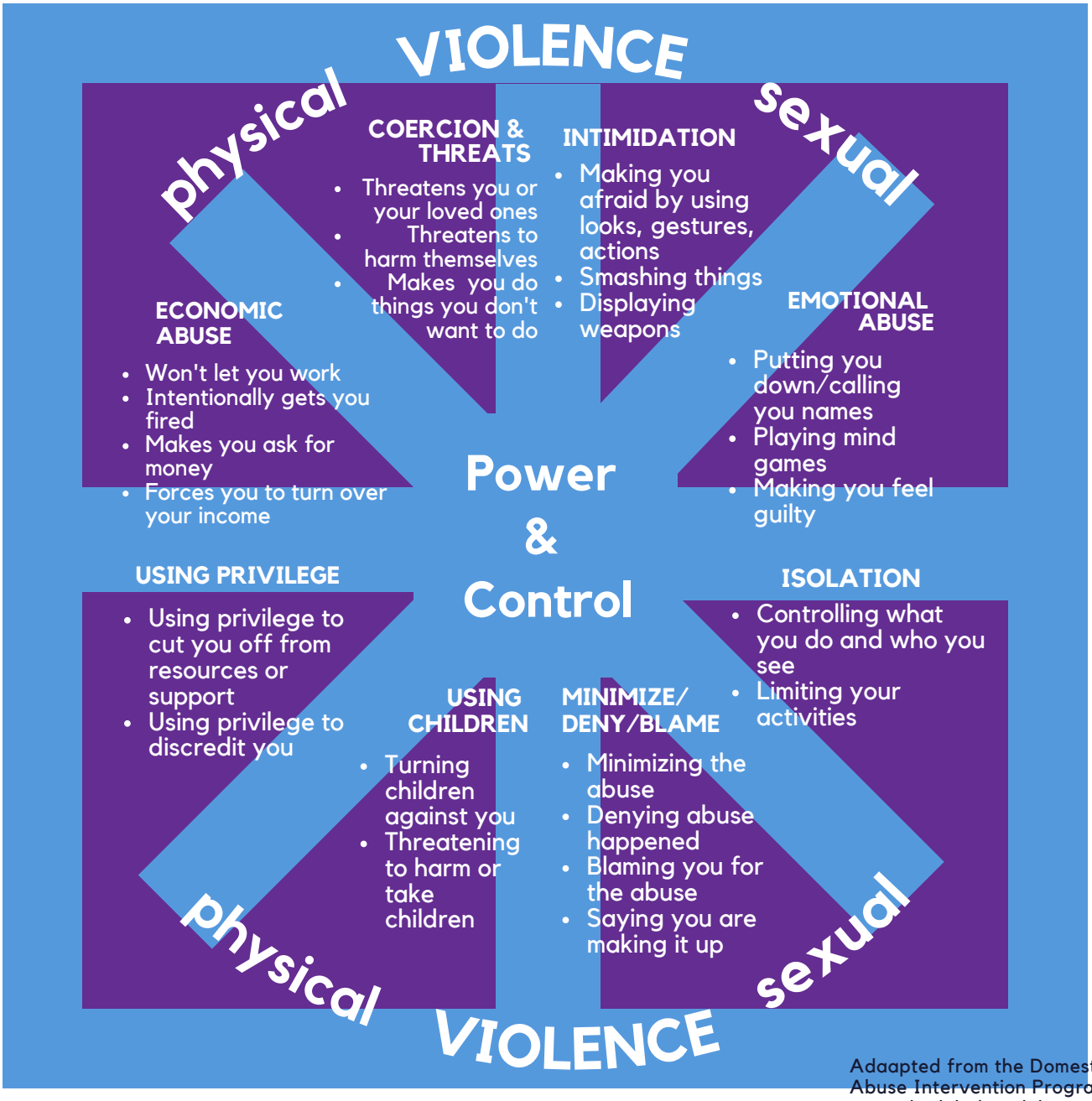
If a patient discloses that a pet or animal has been harmed at home, ask screening questions related to intimate partner violence, child abuse, and/or elder abuse.

Report animal cruelty at:
https://animalservices.delaware.gov/report_violation/25

Learn more at the National LINK Coalition website (scan qr code).
https://nationallinkcoalition.org/

F: 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.



Adaapted from the Domestic Abuse Intervention Programs
www.theduluthmodel.org

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

BARRIERS TO LEAVING

There are many reasons a survivor may not leave an abusive relationship. Some identified barriers are:

Fear
Economic dependence
Children
Religious or societal pressure
Hope of change
Shame
Fear of the legal system
It's the safest option at the time

CHAPTER III: STRANGULATION AND TRAUMATIC BRAIN INJURY

A: PREVALENCE AND IMPACT

STRANGULATION

Strangulation is defined as any pressure placed on the outside of the neck that prevents breathing and/or blood flow to and from the brain.[13]

TRAUMATIC BRAIN INJURY

A traumatic brain injury (TBI) is a brain injury that is caused by an outside force, such as a forceful bump, blow, or jolt to the head or body.[8]

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.

83% of survivors report having been strangled by an intimate partner at least once.[9]

50% of strangulation victims did not have any visible injury. **Strangulation often leaves no marks or any other external evidence of injury**, even when internal injury is present.[14]

750% more likely a victim of strangulation will be killed by their abuser compared to victims who are never strangled. **Odds for homicide increase dramatically** for victims who have been previously strangled.[13]

92% of women who have experienced IPV, including strangulation, are estimated to have suffered some type of a TBI.[2]

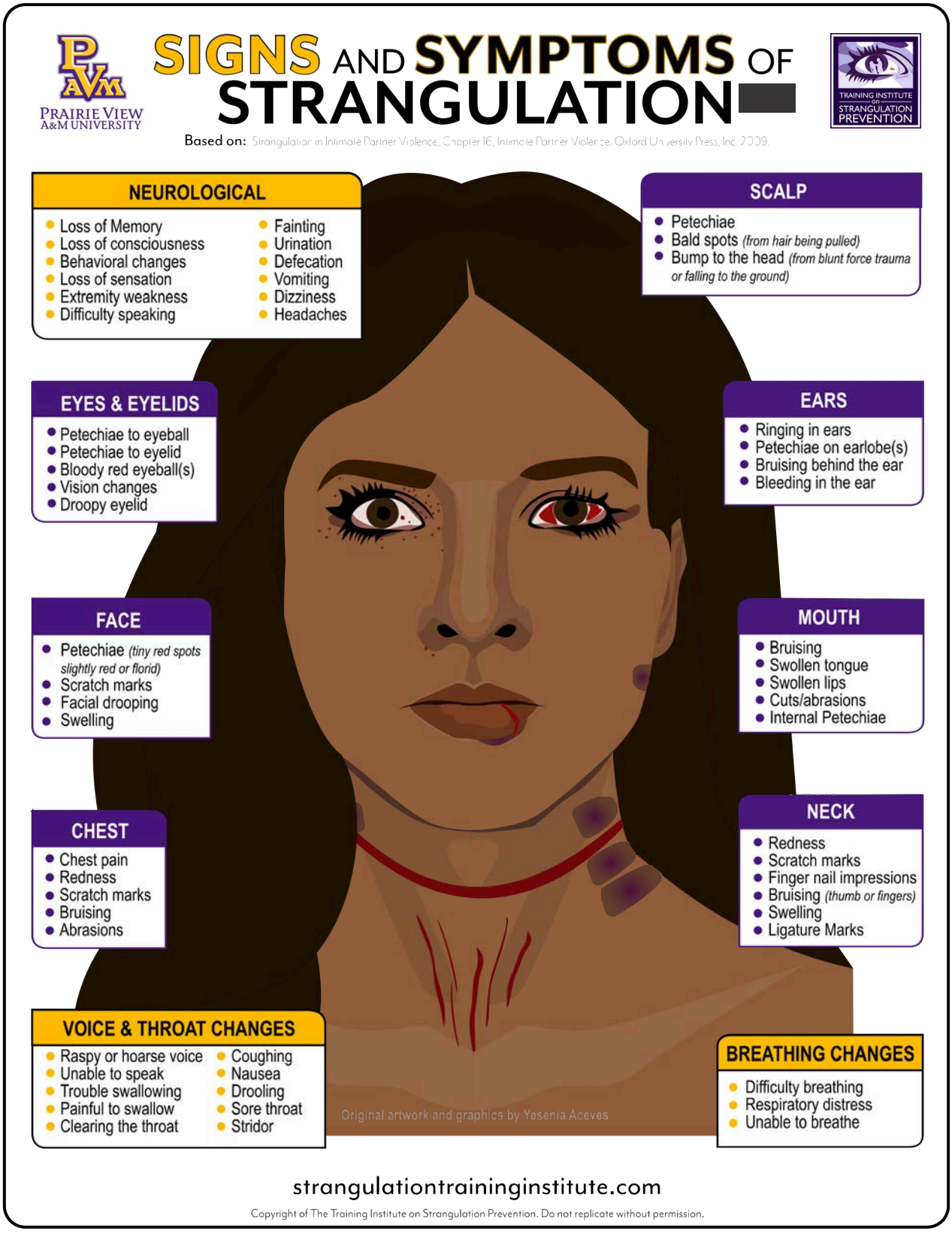
81% of survivors report having been hit in the head or been made to have their head hit another object at least once. **50% report having been hit in the head so many times they lost count.**[9]

30–50% higher risk of TBI caused by physical violence in Latinx, Hispanic, and Asian-American survivors.

Most people use the term "choking" to refer to behavior that is actually strangulation, especially young people. **Strangulation is a significant risk factor for future lethality.** If you suspect a patient has been strangled or if a patient discloses they have been choked/strangled, **be sure to offer resources.**

B: STRANGULATION - SIGNS & SYMPTOMS

Strangulation often leaves little to no sign of external injury. **Around 50% of patients present with no visible signs of injury.**[14] Someone who has been strangled may look and say they are fine, but internal injury and/or delayed complications can still pose a serious threat or even be fatal.



C: STRANGULATION - SCREENING & EVALUATION

v11.21.22

RECOMMENDATIONS FOR THE MEDICAL/RADIOGRAPHIC EVALUATION OF ACUTE ADULT NON/NEAR FATAL STRANGULATION

Prepared by **Bill Smock, MD; Bill Green, MD;** and **Sally Sturgeon, DNP, SANE-A**

Endorsed by the **National Medical Advisory Committee**:
Cathy Baldwin, MD; Ralph Riviello, MD; Sean Dugan, MD; Steve Stapczynski, MD; Ellen Tailiaferro, MD; Michael Weaver, MD

GOALS:

1. Evaluate for acute medical conditions requiring immediate management/stabilization
2. Evaluate carotid and vertebral arteries for injuries (dissection/thrombosis)
3. Evaluate airway structures and other bony/cartilaginous/soft tissue neck structures

STRANGULATION PATIENT PRESENTS TO THE EMERGENCY DEPARTMENT

HISTORY (**ANY** of the following; current **OR** assault related and now resolved)

1. Loss of consciousness
2. Visual changes: "spots," "flashing lights," "tunnel vision"
3. History of altered mental status: "dizzy," "confused," "lightheaded," "loss of memory," "any loss of awareness"
4. Breathing changes: "I couldn't breathe," "difficulty breathing"
5. Incontinence (bladder or bowel)
6. Neurologic symptoms: seizure-like activity, stroke-like symptoms, headache, tinnitus, decreased hearing, focal numbness, amnesia
7. Ligature mark or neck contusion
8. Neck tenderness or pain/sore throat/pain with swallowing
9. Change in voice: unable to speak, hoarse or raspy voice

PHYSICAL EXAM (**ANY** Abnormality)

1. Functional assessment of breathing, swallowing, and voice
2. Thorough examination of neck, eyes, TMs, oral mucosa, nose, airway, upper torso for: tenderness, swelling, bruising, abrasions, crepitance, bruit
3. Venous congestion/petechial hemorrhages/ scleral hemorrhages
4. Ligature mark **= HIGH RISK**
5. Tenderness of airway structures/ carotid arteries **= HIGH RISK**
6. Mental status/complete neurologic exam

CONSIDER ADMINISTRATION OF ONE 325MG ASPIRIN IF THERE IS ANY DELAY IN OBTAINING A RADIOGRAPHIC STUDY

RECOMMENDED RADIOGRAPHIC STUDIES TO RULE OUT LIFE-THREATENING INJURIES* (including delayed presentations of up to 1 year)

1. CT Angio of carotid/vertebral arteries (GOLD STANDARD for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) or
2. MRA of carotid/vertebral arteries
3. Carotid Doppler Ultrasound (NOT RECOMMENDED - Unable to adequately evaluate vertebral arteries or proximal internal carotid arteries)
4. Plain Radiographs (NOT RECOMMENDED - Unable to evaluate vascular and soft-tissue structures)
5. Consider fiberoptic direct laryngoscopy to evaluate possible larygeal injury or airway compromise

POSITIVE RESULTS

1. Consult Neurology/Neurosurgery/Trauma Surgery for admission
2. Consider ENT consult for laryngeal trauma or dysphonia
3. Perform a lethality assessment per institutional policy

NEGATIVE RESULTS

Discharge home with detailed instructions, including a lethality assessment, and to return to ED if:
neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

IF THE CTA IS NEGATIVE, CONSIDER OBSERVATION OF NEAR-FATAL STRANGULATION PATIENT IF THE AIRWAY IS OF CONCERN. OBSERVATION HAS NO ROLE IN RULING OUT A VASCULAR INJURY.

Graphic Design by Yesenia Aceves

**References on page 2*

D: TBI - SIGNS, SYMPTOMS, AND SCREENING

Traumatic Brain Injury (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.

SYMPTOMS OF TRAUMATIC BRAIN INJURY

(MOST COMMONLY REPORTED)[1,3,4,5,7,9]

MEMORY LOSS

DIZZINESS

DEPRESSION

DIFFICULTY UNDERSTANDING DIRECTIONS

DIFFICULTY UNDERSTANDING SPEECH OR WRITING

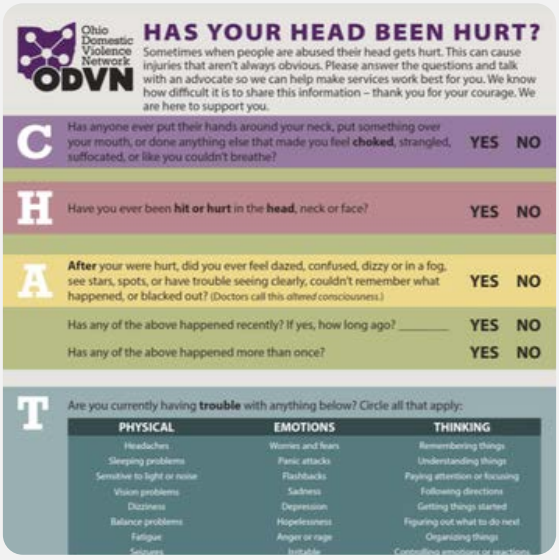
FATIGUE OR WEAKNESS

DIFFICULTY REGULATING ANGER

PERSISTENT HEADACHES

Traumatic brain injuries can occur during strangulation incidents or other assaults where there is trauma to the head. If you suspect a patient has been strangled or has a possible brain injury, consider utilizing the "HAS YOUR HEAD BEEN HURT?" screening tool produced by The Center on Partner-Inflicted Brain Injury.

SCREENING: HAS YOUR HEAD BEEN HURT?



Ohio Domestic Violence Network ODVN

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

A **After** your were hurt, did you ever feel dazed, confused, dizzy or in a fog, see stars, spots, or have trouble seeing clearly, couldn't remember what happened, or blacked out? (Doctors call this *altered consciousness*.) YES NO

Has any of the above happened recently? If yes, how long ago? _____ YES NO

Has any of the above happened more than once? YES NO

T Are you currently having **trouble** with anything below? Circle all that apply:

PHYSICAL	EMOTIONS	THINKING
Headaches	Worries and fears	Remembering things
Sleeping problems	Panic attacks	Understanding things
Sensitive to light or noise	Flashbacks	Paying attention or focusing
Vision problems	Sadness	Following directions
Dizziness	Depression	Getting things started
Balance problems	Hopelessness	Figuring out what to do next
Fatigue	Anger or rage	Organizing things
Seizures	Irritable	Controlling emotions or reactions

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

Includes questions on suicide, substance use, and other health concerns.

Helps connect, identify, provide information, accommodate and support referrals.

Access the full tool on the following page.

D: TBI - SIGNS, SYMPTOMS, AND SCREENING

Ohio Domestic Violence Network ODVN | The Center on Partner-Inflicted Brain Injury

HAS YOUR HEAD BEEN HURT?

When your head, neck, or face gets hurt, the injuries might not be visible or show up right away but can impact your brain and your life in many ways. Please complete this CHATS form and work with your advocate to get support after a head injury.

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
Have you ever passed out or lost **consciousness** from an overdose or drug use, a medical issue, or something else?	YES	NO

H

Have you ever been **hit or hurt** in the **head, neck, or face**?	YES	NO
Have you ever **hurt your head, neck, or face** in any other way? Like hitting your head on something, in a fall or accident, while using alcohol or drugs, severe shaking, or a car crash?	YES	NO

A

After you were hurt, did you ever feel dazed, confused, dizzy or in a fog, see stars, spots, or have trouble seeing clearly, couldn't remember what happened, or blacked out? (Doctors call this *altered consciousness*.)	YES	NO
Has any of the above happened recently? If yes, how long ago? _____	YES	NO
Has any of the above happened more than once?	YES	NO

T

Are you currently having **trouble** with anything below? Circle all that apply:

PHYSICAL	EMOTIONS	THINKING	ACCESS TO
Headaches	Worries and fears	Remembering things	Food
Sleeping problems	Panic attacks	Multi-tasking	Health Care/Insurance
Sensitive to light or noise	Flashbacks	Paying attention or focusing	Employment
Vision problems	Sadness	Problem solving	Housing
Dizziness	Depression	Getting things started	Utilities
Balance problems	Hopelessness	Figuring out what to do next	Transportation
Fatigue	Anger or rage	Organizing things	Childcare
Seizures	Irritable	Controlling emotions or reactions	Phone

Are you having thoughts of suicide?	YES	NO
Are you struggling with alcohol or drugs?	YES	NO
Are you having any other health issues you want to share with us?	YES	NO

S

Even if you did not go, have you or anyone else (like a friend or family member) ever thought you should **see a doctor or a counselor**, go to the emergency room, or get help for anything above?	YES	NO
Do you want to **see** anyone for or need help with anything above?	YES	NO

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.[1]

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.[2]

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.[1]

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

A: 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.

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

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 the Documentation chapter.)

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.
- 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.
- Rember that survivors are the experts of their lived experiences.
- 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.***

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

AVOIDING BLAME AND JUDGMENT

- Avoid assigning any blame. Ask questions in a nonjudgmental manner.
- Avoid 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.

BUILDING RESOURCES

- Have educational materials like posters with local hotline numbers in multiple places: bathrooms, exam rooms, waiting rooms, hallways. *Visit ipvhealth.org*
- Have materials in multiple languages and reflecting various cultures.
- Plan to have a way for patients to call DV hotlines or other resources if needed.
- Familiarize yourself with local and national LGBTQIA+ specific resources.
- Consider multiple screening options: verbal and non-verbal options written on cards to have in exam rooms to hand to patients or electronic screening methods.
- Build connections with local DV agencies to strengthen warm referrals.
- Get training. *Domestic Violence Coordinating Council and the Delaware Coalition Againt Domestic Violence host trainings for healthcare professionals. To request a DVCC training, please complete the training request form or email: DVCC.Trainings@delaware.gov.*

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.

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).

Transgender victims are more likely to experience intimate partner violence in public, compared to those who do not identify as transgender[2]

B. UNIVERSAL EDUCATION AND SCREENING FOR DOMESTIC VIOLENCE

Why Universal Education?

When traditional IPV screening is conducted alone in clinical settings, research indicates that the disclosure rates are low, approximately 7% despite IPV being prevalent.[3] There are many reasons survivors may not want to disclose abuse such as, fear of judgment, emotional distress, privacy concerns or not disclosing may be the safest option at the time.

Furthermore, a survivor may not recognize their experience as abuse and often times may disclose after receiving education about IPV. Ultimately survivors deserve autonomy and for a more trauma informed approach, disclosure should not be the goal. Universal education approaches allow for all patients to receive information and resources about IPV regardless of disclosure.

CUES Model

CUES stands for *Confidentiality, Universal Education and Support* and is an evidence-based universal education intervention created by Futures Without Violence. CUES has shown positive outcomes for patients and providers. This model can be used in various medical settings and can be used alongside existing screening tools.

For more information visit ipvhealth.org

UNIVERSAL SCREENING

- Confidentiality
- Universal Education
- Support

STEP 1: CONFIDENTIALITY

- Ensure that the patient can be alone in a private setting before asking any questions about domestic violence or conducting verbal screening. If you cannot get the patient alone in a private setting, the screening should not be done.
- Always review the limits of confidentiality, before doing any assessments. (See Chapter on Confidentiality.)
- If children over the age of two are present, consider non-verbal screening methods to prevent the child from hearing potentially traumatizing information.

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**

For more information see Chapter V - Legal Mandates.

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."

Best Practice Tip:
When needed, use professional interpreters.
Never use a child or a patient's family or friends.

STEP 2: UNIVERSAL EDUCATION

Universal Screening + Universal Education

GOAL: Every patient leaves with information regardless of disclosure

While assessment questions for domestic violence may be contained in self-administered questionnaires or computerized interviews, having a conversation and offering information should also be a part of the face-to-face assessment. There are many reasons a survivor may not want to disclose at the time. Research indicates that despite IPV being prevalent, disclosure rates from screening in clinical settings are low.[3] Adopting a universal education approach with screening helps to foster survivor autonomy and increase access to IPV resources.

- Start by normalizing the conversation to reduce stigma and promote empowerment. This approach helps survivors know you are a resource even if they are not ready to disclose.

  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.*"

- Provide the patient with information on the signs of IPV that include local resources and hotline numbers. Ensure resources are available in multiple languages.

Where to get resources

Futures Without Violence Safety Cards- Free Pocket-sized foldable card with information, self-assessment and resources. Available in multiple languages.

Contact the Domestic Violence Coordinating Council or the Delaware Coalition Against Domestic Violence for additional free resources.

Best Practice Tip:
Make sure it's safe for your patient to take resources and information with them when they leave your care. Give two copies of resources to promote helping others.

STEP 3: SUPPORT

- If a patient discloses, it's important to validate their experience.
  Sample Language: *"Thank you for sharing this with me" or "I'm sorry to hear this is happening to you."*

- Ask if they have immediate safety concerns. If yes, offer support with calling the DV hotline for immediate safety planning. *See the Safety Screening section of this chapter.*

- Provide a warm referral to domestic violence services. It is not necessary for the healthcare providers to know every domestic violence resource available. When in doubt, refer to the 24-hour DV hotlines.
  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."*

DV-Community Health Workers

Can meet the patient where they are, provide transportation, safety planning, and help accessing medical and social services and other DV advocacy support.

302-757-2137 (NCC) OR 302-422-8058 (KENT/SUSSEX)

24-HOUR DOMESTIC VIOLENCE HOTLINES

(302) 762-6110 : New Castle

(302) 678-3886 : Northern Kent

(302) 422-8058 : Kent & Sussex

(302) 745-9874 : Bi-lingual

ADDITIONAL RESOURCES CAN BE FOUND IN CHAPTER XVII AT THE END OF THIS MANUAL

C: 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, themself, 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.

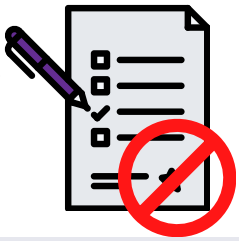
YOU CAN ALWAYS CALL A 24/7 DOMESTIC VIOLENCE HOTLINE TO HAVE AN ADVOCATE HELP THE PATIENT MAKE A SAFETY PLAN.

D: 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.

1. 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.

2. 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.

3. 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.

4. 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.

5. Not Sure How to Respond if Patient Discloses

HOW TO OVERCOME IT

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

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

privately calling the Domestic Violence Hotlin on a phone belonging to t HCP, before they leave yo office.

"I am so sorry this happened to you."

"Thank you for sharing this with me."

"How can I help you?"

ow every resource available. efer to the Domestic Violence line or a community resource, allow trained professionals to further assist the patient. esources are available 24/7.

CHAPTER V: LEGAL MANDATES

Note to Reader

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

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.

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.	Any 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 REPORTING REQUIRED? A QUICK LIST

REPORTING REMINDER: Delaware law does not require mandatory reporting of domestic violence. But some incidents involving children do trigger a mandated report. **Except in those circumstances that require mandatory reporting, it is a breach of confidentiality to call law enforcement without the patient's consent.**

When a mandated report is required & where to make a report:

Suspected child abuse - 16 Del. C. §903
Reportable to Delaware Division of Family Services (DFS) by calling **1-800-292-9582** or by submitting the online report form at iseethesigns.delaware.gov

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

Child Abuse: Who and What are Mandated?

ALL ADULTS IN DELAWARE ARE MANDATED TO REPORT CHILD ABUSE & NEGLECT
16 DEL C. § 903.

Any person, agency, organization or entity who knows or in good faith suspects child abuse, neglect, or human trafficking shall make a report to the Department in accordance with § 904 of this title. While a person may also notify law enforcement for the purpose of rendering assistance to the child in question or investigating the cause of the child's injuries or condition, the person is still required to report the suspected abuse to the Department.

Nature & Content of Report, To Whom Made?

16 DEL C. § 904.

(a) A report of known or suspected child abuse, neglect, or human trafficking **must be made orally by immediately** contacting the Department's report line for the following circumstances:

(1) Sexual abuse or suspected human trafficking where the alleged perpetrator has access to the alleged victim.
(2) Child death.
(3) A child with a current physical injury.
(4) A child who requires immediate medical attention or an immediate mental health evaluation.
(5) A child who has no caregiver, is currently unsupervised, or is living in conditions that are immediately hazardous to the child's health or safety.

(b) A report of known or suspected child abuse, neglect, or human trafficking which does not meet the criteria in subsection (a) above, may be made orally or through the Department's online reporting portal.

(c) An individual with knowledge of child abuse, neglect, or human trafficking or knowledge that leads to a good faith suspicion of child abuse, neglect, or human trafficking may not rely on another individual who has less direct knowledge to call the aforementioned report line.

Legal Definitions for Child Abuse Reporting:

CHILD ABUSE (10 DEL C. § 901.)

(1) "Abuse" or "abused child" means that a person:
- a. Causes or inflicts sexual abuse on a child; or
- b. Has care, custody or control of a child, and causes or inflicts:
  1. Physical injury through unjustified force as defined in §468 of Title 11;
  2. Emotional abuse;
  3. Torture;
  4. Exploitation; or
  5. Maltreatment or mistreatment.

Witnessing DV:

When a child witnesses violence against their parent, it may constitute emotional abuse or child maltreatment and if so, it must be reported. Use your professional judgment and these legal definitions to determine if the threshold for a mandated report has been met.

UNJUSTIFIED FORCE (11 DEL C. §468.)

The legal justification for use of force in the care, discipline or safety of others is defined in §468 of Title 11. Unjustified force is force that is unreasonable and beyond moderate, is not used for the purpose of safeguarding or promoting the welfare of the child, and is not intended to benefit the child. "The force shall not be justified if it includes, but is not limited to, any of the following: Throwing the child, kicking, burning, cutting, striking with a closed fist, interfering with breathing, use of or threatened use of a deadly weapon, prolonged deprivation of sustenance or medication, or doing any other act that is likely to cause or does cause physical injury, disfigurement, mental distress, unnecessary degradation or substantial risk of serious physical injury or death."

EMOTIONAL ABUSE (10 DEL C. § 901.)

(10) "Emotional abuse" means threats to inflict undue physical or emotional harm, and/or chronic or recurring incidents of ridiculing, demeaning, making derogatory remarks or cursing.

EXPLOITATION (10 DEL C. § 901.)

(11) "Exploitation" means taking advantage of a child for unlawful or unjustifiable personal or sexual gain.

MISTREATMENT OR MALTREATMENT (10 DEL C. § 901.)

(16) "Mistreatment" or "maltreatment" are behaviors that inflict unnecessary or unjustifiable pain or suffering on a child without causing physical injury. Behaviors included will consist of actions and omissions, ones that are intentional and ones that are unintentional.

Legal Definitions for Child Abuse Reporting:

NEGLECT OR NEGLECTED CHILD (10 DEL C. § 901.)

(18) "Neglect" or "neglected child" means that a person:

a. Is responsible for the care, custody, and/or control of the child; and

b. Has the ability and financial means to provide for the care of the child; and

1. Fails to provide necessary care with regard to: food, clothing, shelter, education, health, medical or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being; or
2. Chronically and severely abuses alcohol or a controlled substance, is not active in treatment for such abuse, and the abuse threatens the child's ability to receive care necessary for that child's safety and general well-being; or
3. Fails to provide necessary supervision appropriate for a child when the child is unable to care for that child's own basic needs or safety, after considering such factors as the child's age, mental ability, physical condition, the length of the caretaker's absence, and the context of the child's environment.

In making a finding of neglect under this section, consideration may be given to dependency, neglect, or abuse history of any party.

HUMAN TRAFFICKING (11 DEL C. § 787.)

(13) "Human trafficking" means the commission of any of the offenses created in subsection (b) of this section;

(b) Prohibited activities. —

(1) Trafficking an individual. — A person is guilty of trafficking an individual if the person knowingly recruits, transports, harbors, receives, provides, obtains, isolates, maintains, advertises, solicits, or entices an individual in furtherance of forced labor in violation of paragraph (b)(2) of this section or sexual servitude in violation of paragraph (b)(3) of this section.

(2) Forced labor. — A person is guilty of forced labor if the person knowingly uses coercion to compel an individual to provide labor or services, except where such conduct is permissible under federal law or law of this State other than 79 Del. Laws, c. 276.

(3) Sexual servitude. — a. A person commits the offense of sexual servitude if the person knowingly:

1. Maintains or makes available a minor for the purpose of engaging the minor in commercial sexual activity; or
2. Uses coercion or deception to compel an adult to engage in commercial sexual activity.

TEMPORARY EMERGENCY CUSTODY (16 DEL C. § 907.)

(a) A police officer, nurse practitioner, or a physician who reasonably suspects that a child is in **imminent danger** of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian, or others legally responsible for the child's care.

(b) Any person taking a child into temporary emergency protective custody under this section shall immediately notify the Department, in the county in which the child is located, of the person's actions and make a reasonable attempt to advise the parents, guardians, or others legally responsible for the child's care. In notifying the Department, such person shall set forth the identity of the child and the facts and circumstances which gave such person reasonable cause to believe that there was imminent danger of serious physical harm or threat to the life of the child. Upon notification that a child has been taken into temporary emergency protective custody, the Department shall immediately respond in accordance with § 906 of this title to secure the safety of the child which may include ex parte custody relief from the Family Court if appropriate.

(c) Temporary emergency protective custody for purposes of this section **may not exceed 4 hours** and must cease upon the Department's response.

(d) For the purposes of this section, "temporary emergency protective custody" means temporary placement **within a hospital, medical facility,** or such other suitable placement; provided, however, that an abused or neglected child may not be detained in temporary custody in a secure detention facility.

(e) A Department investigator conducting an investigation pursuant to § 906 of this title has the same authority as that granted to a police officer, nurse practitioner, or physician in subsection (a) of this section, subject to all the same conditions as those listed in subsections (a) through (d) of this section, provided that the child in question is located at a school, day care facility, or child care facility at the time that the authority is initially exercised. In no other case may an employee of the Department exercise custody under this section.

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 the Division of Family Services (DFS) when a child is experiencing child abuse or neglect as defined in the statute.

Remember that reporting under the statute does not necessarily result in an investigation. DFS will review the information using evidence-based tools and determine whether an investigation is appropriate.

Use Minimal Fact Questions

If contact with the victim is necessary, use the Minimal Fact Questions. It is best to avoid causing triggers or re-traumatization if possible. It is not necessary to collect complete information in order to have what is required for a report.

- What happened?
- Who did that to you?
- Are there other victims/witnesses?
- Where did this happen?
- When did this happen?

WHEN IN DOUBT, REPORT.

What information is needed when reporting?

- Demographic information
- A description of the abuse or why the child is at risk of child abuse or neglect
- Known information about the parents or siblings
- Known information about the alleged child victim's physical health, mental health, educational issues, parents or siblings
- Whether medical attention was required for any injuries the child had
- Known information that could put the child's or worker's safety in peril, such as the presence of alcohol, drugs, weapon, dangerous animal or criminal behavior

What Happens after a Report is Made?

To learn about the steps that DFS will take after a report is made, scan the qr code which goes to: iseethesigns.delaware.gov

Mandatory Reporting of Child Abuse:

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

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

Trust Your Gut

There is no clear, precise chart for reporting. This manual provides the legal definitions for child abuse and all of its related terms as a reference for determining whether behavior rises to the level of a mandatory report.

If you suspect that what a child witnessed or experienced constitutes abuse, it is your duty to report it. The child's safety is of the utmost importance. You may be the first or only person to be aware of what has happened and to report.
When in doubt, report.

What is a "Good Faith" Report?

Anyone who makes a good faith report based on reasonable grounds is immune from prosecution or retaliation. "Good faith" is a legal term meaning that you reported based on a sincere belief that abuse or wrongdoing have occurred.

Consequences of Not Reporting

Individuals who fail to report child abuse or neglect may be liable for a civil penalty. The Division of Family Services reports all persons, agencies, organizations, and entities to the Department of Justice for investigation if they fail to make mandatory reports of child abuse or neglect. The civil penalty may be up to $10,000 for the first violation, or $50,000 for subsequent violations.

WHERE TO REPORT

All suspected child abuse and neglect of any child in the state of Delaware must be reported to the DFS Report Line at 1-800-292-9582.

Professionals licensed by the Division of Professional Regulation or Department of Education may NOT report anonymously - you must leave your name. (16 Del. C.§ 905.)

An online reporting form is available for situations that do not require an oral report. (Situations requiring an oral report are outlined in 16 Del C. § 904.) Information about what happens after a report is made, the online reporting form and other resources are available at: iseethesigns.delaware.gov (scan the qr code.)

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

Training on Mandatory Reporting

The Office of the Child Advocate provides training and resource materials regarding mandatory reporting at (scan qr code): https://courts.delaware.gov/childadvocate/training.aspx

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:

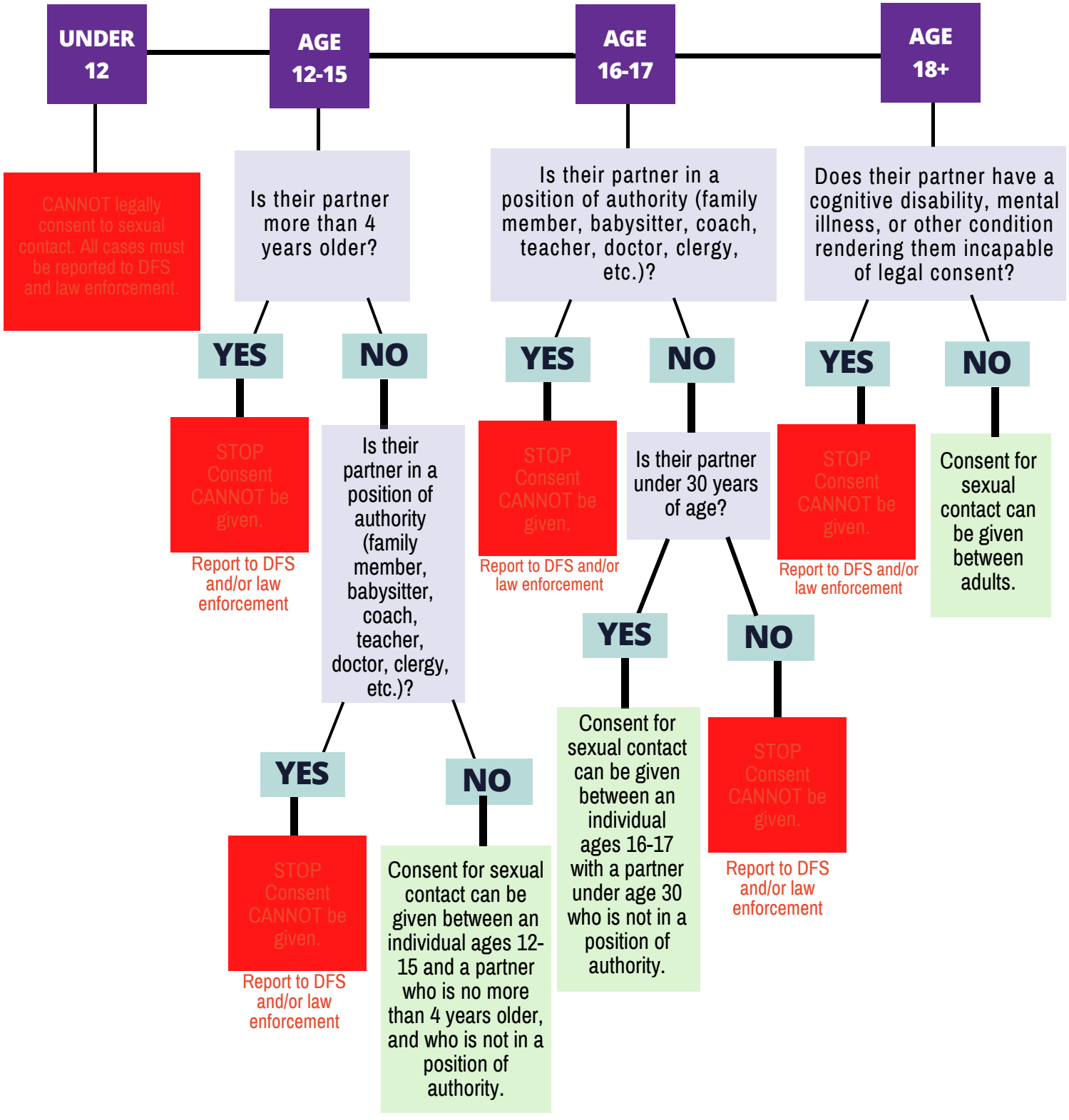
01 Committed an act that would fall under any of the seven categories in Section A above or

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
1-888-277-4302
Or submit a report online:
https://dhss.delaware.gov/dsaapd/aps/

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 +

The fact that someone is over a certain age DOES NOT automatically trigger a mandated report to Adult Protective Services (APS).

DE Code only requires HCPs to report suspected abuse of a person who is **substantially impaired** or **incapacitated.**

SUBSTANTIALLY IMPAIRED

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.

INCAPACITATED

A person who is incapacitated is defined as a person for whom a guardian of person or property, or both, shall be appointed.

APS REFERAL

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!

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 1-888-277-4302.**

WHEN TO REFER

If you suspect or your patient has disclosed domestic violence, offer a domestic violence resource such as a DV hotline.

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 phone**

Unless mandated to report, always respect confidentiality and never call a resource without your patient's permission.

For information about abuse of vulnerable populations, see Chapter VIII - Health Disparities and IPV and Chapter X - Elder Abuse of this manual.

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.	Resource Guide for Mandatory Reporting of Child Abuse & Neglect in Delaware
Financial exploitation of elder or abuse of incapacitated or impaired person	✓	✓	✓	Del. Code tit. 31 §3910	Delaware Services for Aging Adults and People with Disabilities, Adult Protective Services
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 patient's wishes, there is a risk of trauma or re-traumatization to a patient. As a result of the report, the patient 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.

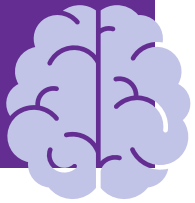
BEST PRACTICE TIP: Prior to conducting assessments or screenings, HCPs should always review their limits of confidentiality with their patients. (See Universal Screening section in Chapter IV.)

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).

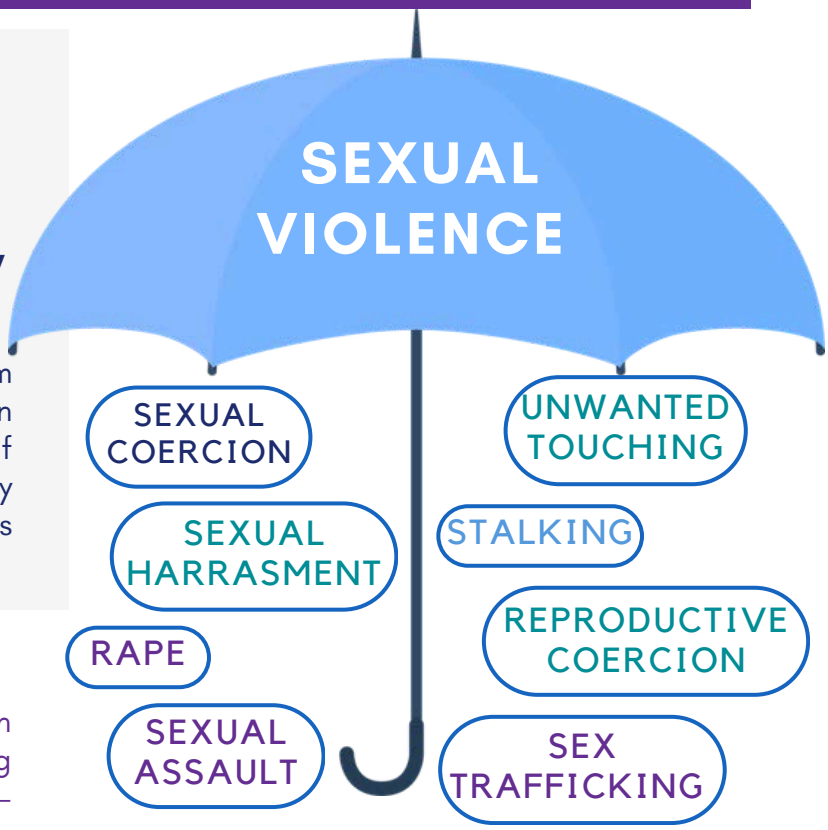


CHAPTER VI: SEXUAL ASSAULT AND SEXUAL VIOLENCE

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. [8,10]



16.2% of adult women in Delaware reported having been forced into non-consensual sex at some point during their lives[3]

1.8% of adult Delaware men reported that they had at some time been forced to have sex without their consent[4]

33% of rapes are committed by a current or former spouse or partner[7]

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

CONSEQUENCES OF SEXUAL VIOLENCE CAN INCLUDE...

- DIFFICULTY SLEEPING
- SUBSTANCE/ ALCOHOL USE
- DEPRESSION
- SELF HARM OR SUICIDE
- 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.[9]

PREGNANCY PRESSURE & COERCION

- Forcing a partner to terminate a pregnancy
- Forcing a partner to carry a pregnancy to term
- Threatening harm if a partner 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 relationship if the partner 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[9]

HOMICIDE

THE MAJORITY OF PREGNANCY-ASSOCIATED HOMICIDES WERE COMMITTED BY AN INTIMATE PARTNER[1,11]

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

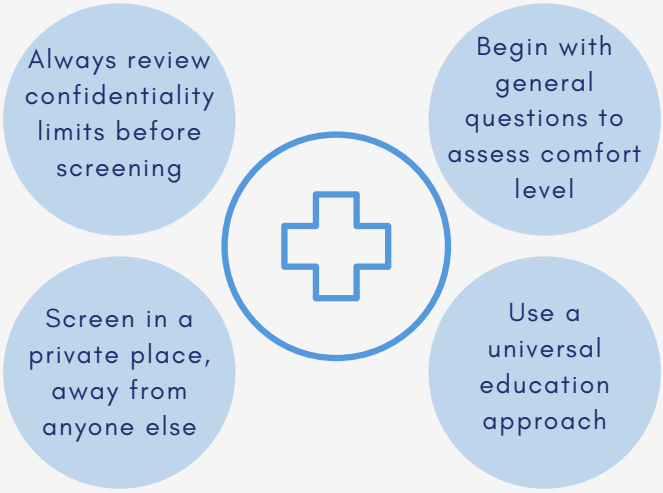
Annual Physicals

OB-GYN Appointments

Emergency Room Visits

Prenatal and Postpartum Appointments

PRACTICE TRAUMA-INFORMED SCREENING



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

Forensic Nurse Examiners (FNEs), also known as Sexual Assault Nurse Examiners (SANEs), are nurses who are specially trained to work with survivors of sexual violence. SANEs are trained in a trauma-informed approach, evidence collection, strangulation, domestic violence, and other topics to best serve survivors after an assault.

WHAT SEXUAL ASSAULT NURSES EXAMINERS CAN DO

DISCUSS PATIENT'S WISHES & WHAT THEY ARE COMFORTABLE WITH

PERFORM A FORENSIC MEDICAL EXAM

CONTACT LAW ENFORCEMENT IF PATIENT WISHES OR IF MANDATED

COLLECT EVIDENCE

CONNECT TO COMMUNITY BASED SUPPORTS

BENEFITS OF CONNECTING WITH A COMMUNITY-BASED ADVOCATE

Advocates provide specialized, confidential support that complements the medical and forensic services offered in the healthcare setting. Connecting patients with an advocate ensures they receive continuous, compassionate assistance throughout their recovery and any subsequent legal or social service processes.

WHAT TO KNOW 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.

For adults & teens above the age of 12*, kits can be collected up to 5 days (160 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.

*For pediatric patients below the age of 12, kits can be collected up to 3 days (72 hours) after an assault has occured.

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 as traditional forms of abuse, or electronically, such as through social media, phone apps, etc. It may look like repeated texting, posting sexual pictures of a partner online without consent, checking a partner's phone, or stalking.

1 in 12 high school students has been purposefully hit, slapped, or physically hurt by an intimate partner[3]

1 in 4 teens

ARE HARRASSED ONLINE BY A DATING PARTNER[1]

PREVALENCE BY AGE[1,6,7]

TDV AND BULLYING ARE CONNECTED

Middle school youth who perpetrated bullying were **4X more likely** to perpetrate TDV later that year.[9]

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 or “choking”
- 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

Adolescence is a critical developmental period characterized by identity formation, relationship building, and increasing autonomy. When dating violence occurs during this time, it can disrupt healthy development, leading to physical, mental health, and behavioral challenges that can extend into adulthood.

Mental Health

Adolescent girls who experienced physical dating violence report suicide attempt rates **3X higher** than the national average.[2]

Youth who experience TDV report **elevated rates** of depression and anxiety persisting into adulthood.[4]

LGBTQ+ youth face compounded vulnerabilities, including **higher rates** of depression, anxiety and isolation when combined with TDV exposure.[6]

Substance Use

Men who experienced TDV report **increased rates** of substance use.[5]

Binge drinking and depression are associated with **increased risk** for TDV revictimization in sexual minority youth.[10]

Women with TDV histories show **increased rates** of binge drinking.[10]

Reproductive Health

Youth experiencing dating violence are exposed to more **unsafe sexual practices** compared to youth who are not experiencing TDV.[6]

LGBTQ+ youth experiencing TDV have an **elevated STI risk** that is compounded by healthcare access and discrimination.[6]

D: RESPONSE

SCREENING CONSIDERATIONS WITH ADOLECENTS

- ✓ Always review confidentiality limits before screening.
- ✓ Normalize discussing healthy relationships in multiple settings and routinely. *Examples: Well visits, reproductive health visits, school-based health visits.*
- ✓ Only screen alone and in a private setting. *Do not screen with family or friends present.*
- ✓ Use direct questions relevant to their developmental stage. Do not assume they know the signs of dating violence. *Example: Has your partner posted things to social media about you that you didn't want posted?*
- ✓ Universal Education Approach: Repetitive messages on healthy relationships are important. Provide information in multiple forms and places: bathrooms, waiting areas and when safe, offer information to all patients regardless of disclosure. Consider digital resources like *safeandrespectful.org* and *loveisrespect.org*.

For more information on evidence-based screening practices, refer to Chapter IV - Screening.

RESPONDING TO DISCLOSURES

Validate their experience and affirm that they did the right thing by getting help.
"*Thank you for sharing with me. I know it can be really difficult to talk about something so personal."*

Assess their immediate safety.
"Is it safe to leave today?"

Offer to help them contact a hotline or resource.
Do not assume they will have a way to safely call.

Domestic violence between dating partners who are **both** under 18 only requires a mandatory report under certain circumstances. *Refer to Section C in **Chapter V - Legal Mandates** for circumstances that would require a mandatory report.*

CHAPTER VIII: HEALTH DISPARITIES & IPV

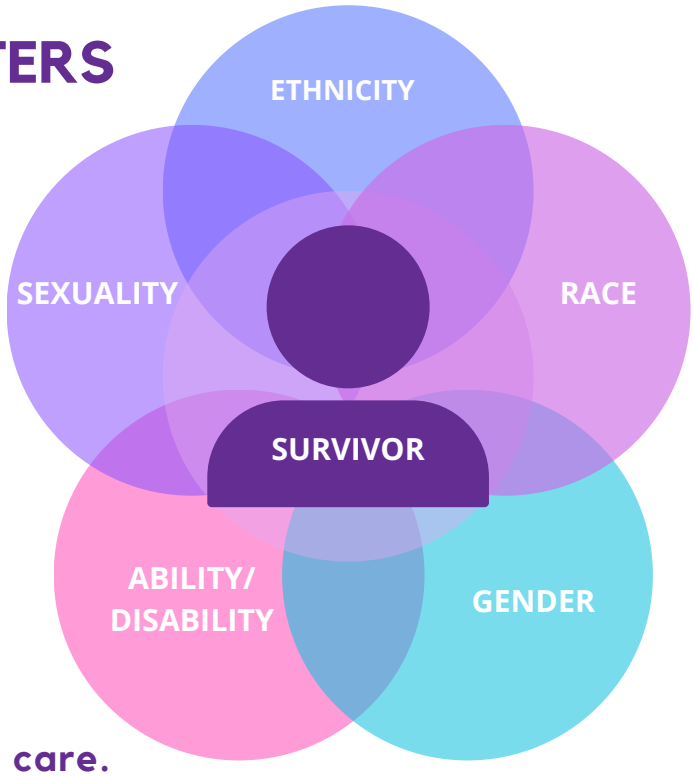
A. INTRODUCTION

Health disparities are measurable health differences that systematically and negatively impact certain groups of people due to social location or identity, including race, class, gender identity, or sexual orientation. These preventable differences can be observed in the risk, prevalence, incidence or mortality rates of a public health issue or condition and in healthcare access and quality. While the impact of IPV is significant for any survivor, that impact can be further compounded in certain groups who also experience health disparities.

Domestic violence may be reported differently based on a person's race, ethnicity, ability, economic situation, gender and/or culture.

INTERSECTIONALITY MATTERS

Intersectionality, a framework coined by Kimberlé Crenshaw, is useful when understanding how **two or more identities** can impact someone's experience receiving treatment after experiencing domestic violence. It is **"a way of thinking about identity and its relationship to power"**[7] that helps practitioners create more inclusivity and equality.



For healthcare providers, applying an intersectional lens is essential to delivering high-quality, equitable, trauma-informed care.

A patient may face multiple, overlapping challenges when accessing care.

When providers understand the layers of a patient's identity, they can better recognize how social and structural inequities shape health outcomes, adjust their approach and create a safe, respectful environment where patients feel heard and validated.

B. PREVALANCE & IMPACT OF HEALTH DISPARITIES RACE/ETHNICITY, LANGUAGE ACCESS

1 in 2 Black/African American, American Indian/Alaskan Native, and multiracial women of color have experienced intimate partner violence in their lifetime.[22]

48% of American Indian/Alaska Native women, report physical violence, sexual violence, and/or stalking by an intimate partner in their lifetime, which is more than **25%** higher than their non-Hispanic white woman counterparts.[10]

THINGS TO CONSIDER

Possible Barriers

- A lack of service providers that look like the survivor or share a common experience[25]
- Fear of receiving care because of their legal status[19]
- A lack of trust due to institutional racism[22]
- Unique care needs because of religious or cultural beliefs[19]

Language access is an important consideration when talking to clients who may have experienced intimate partner violence. It can severely **limit the resources** that clients receive.

WHY IS LANGUAGE INCLUSIVITY SO IMPORTANT?

Reporting DV is a very vulnerable process, and navigating systems can be difficult. **Fear of ostracization** from one's community and **judgment** from providers, compounded with the **inability to communicate one's own story could make reporting more difficult.**[24]

Effective communication between patients and medical providers is at the heart of healthcare; when there is difficulty communicating it causes distrust in that relationship.[2]

A report showed that **1 in 3 Spanish-speaking** female IPV hotline callers reported not being able to access linguistically appropriate services for domestic violence.[22]

Ensuring victims have access to interpreters that are not children or family members is crucial for **establishing trust & gaining accurate information.**[23]

Bilingual and bicultural providers, interpretation services and materials and translated materials and forms are **important steps** medical facilities can take for lessening the gap in care that clients receive.

C. PREVALANCE & IMPACT OF HEALTH DISPARITIES

GENDER & SEXUALITY

Gender is an important consideration when thinking about intimate partner violence. While women experience violence more, **1 in 2 women,** men who experience DV can have difficulty seeking help due to societal expectations and gender socialization.[13,15] Around **1 in 3 men** experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.[15]

Male survivors face unique challenges, i.e., lack of resources, social or cultural factors surrounding manhood.[13]

THINGS TO CONSIDER

Possible Barriers

- Fear of outing sexuality or gender identity by disclosing intimate partner violence
- Fear that disclosure will lead to further violence or discrimination based on sexuality or gender given the history of violence against LGBTQIA+ community
- Assumptions and pre-existing relationship "scripts" might make victims who don't "fit" into those scripts (e.g. male victims or LGBTQIA+ victims) feel they will not be believed or helped
- Health care providers might make unintentional assumptions that impact screening based on assumptions about IPV victimization/perpetration

Additionally, LGBTQIA+ individuals report disproportionately high rates of intimate partner violence. Pre-existing ideas of what a survivor looks like and the script of heterosexual couples perpetrating IPV can make this community susceptible to not being believed and/or hesitant to report or engage with services.

RATES OF REPORTED VIOLENCE AMONG LGBTQIA+ INDIVIDUALS

- **61.1%** of bisexual women, **26%** of gay men, and **37.3%** of bisexual men have reported an experience of rape, physical violence, and/or stalking within an intimate relationship.[16]
- **63%** of lesbian women, **76%** of bisexual women, **60%** of gay men and **53%** of bisexual men have reported experiencing psychological aggression by a partner as some point in their lives.[16]
- **54%** of transgender individuals have experienced some form of IPV.[12]

Due to factors impacting LGBTQIA+ individuals' likelihood to report, data reflecting the prevalence of violence based on what is reported might not even fully reflect rates of violence experienced by this community.

D. PREVALANCE & IMPACT OF HEALTH DISPARITIES PREGNANCY, DISABILITY

PREGNANCY

Pregnancy can be a significant risk factor for violence increasing in a relationship. The World Health Organization calculates that between **2 to 13.5%** of women ever-pregnant, ever-partnered, have suffered intimate partner violence during pregnancy.[7]

For pregnant people of color, there are additional risks. Black women experience significantly higher rates of maternal mortality and other pregnancy-related complications that are associated with systemic racism and bias in healthcare systems.

THINGS TO CONSIDER

Possible Barriers

- Lack of access to medical care, which may delay prenatal care[6, 10]
- More attention being put on the pregnancy rather than individual experiencing IPV
- Fear of contact with Child Protective Services or fear of judgment by law enforcement or medical providers

Women who experience IPV during pregnancy are 3x more likely to suffer perinatal death than women who do not experience IPV.[10]

DISABILITY

THINGS TO CONSIDER

Possible Barriers

- Fear of being moved out of the home
- Not being seen as a credible source of information due to ableism[20]
- Lack of support socially and financially[5]

Individuals with disabilities are **2x more likely to experience IPV victimization** within their lifetime due to multiple factors, including economic status, social isolation, or perceived vulnerability.[5]

Furthermore, people with disabilities are less likely to be screened for IPV. This risk is further compounded with factors like pregnancy. Research shows that people with disabilities were less likely to report having been screened for IPV during prenatal care than those who do not have a disability.

E. PREVALANCE & IMPACT OF HEALTH DISPARITIES
RELIGION & SOCIOECONOMIC STATUS

RELIGION

Religion can be an important consideration when trying to screen for intimate partner violence, as religious practices or beliefs can **impact how those experiencing it respond to the violence**. While one's spiritual practice or religious community can be protective and a source of healing and support, it can also be a barrier to survivor safety as some religions are deeply private, and sometimes conducive to violence.[11]

THINGS TO CONSIDER

- The fear of backlash from religious community for seeking services or for trying to leave intimate partner
- Religious or spiritual doctrine can be used by the abusive partner to justify the abuse, making it challenging for the survivor to identify their experience as abuse

SOCIOECONOMIC STATUS

THINGS TO CONSIDER

Possible Barriers

- Not receiving treatment or screening for IPV due to provider-perceptions[3]
- Lack of access to care (i.e., transportation, medical costs, finding provider who will treat them)[4]

Socioeconomic status can impact the **level of treatment** individuals experience, due to factors such as medical providers perceptions, treatments, and access to care.[3]

National Crime Victimization Survey data show that rates of IPV against women **steadily increase with decreasing household income,** resulting in nearly a seven-fold IPV rate disparity for those with incomes below $75,000 compared with those earning at least $75,000.[18]

Financial abuse is experienced by many survivors, which can increase the barriers they face to leaving partners, accessing medical care and safe housing. *For more information on economic abuse, refer to page 4 of this manual.*

F. SCREENING AND RESPONDING TO DISCLOSURES

Medical care is essential, especially for survivors of IPV. However, differences in health outcomes are shaped by far more than medical care alone. Social determinants account for nearly half of the variances in health outcomes in the United States.[29]

Healthcare providers play a critical role in in advancing health equity by identifying social risks, screening for IPV universally and connecting patients to community based- resources. Healthcare providers can often be the first to notice signs of violence occurring. Conducting warm referrals and partnering with domestic violence agencies is the best way to have a community coordinated response to domestic violence.

Women who talked with their health care providers about the abuse were 4x more likely to use an intervention and 2.6 times more likely to exit the abusive relationship.[16]

WHAT IS HEALTH EQUITY?

The World Health Organization defines Health Equity as being achieved when everyone can attain their full potential for health and well-being.

Screening Tips

- **Use neutral, inclusive language like partner instead of boyfriend/girlfriend.**
- **Always screen alone. *This avoids making the assumption that the person accompanying them is safe.***
- **Provide accessible materials and resources that use plain language and offer resources in the patient's preferred language.**
- **Consider ways you can use written screening tools like Futures Without Violence's Safety Cards.**

See ***Chapter IV - Screening*** for more information.

CHAPTER IX: CHILDREN AND DOMESTIC VIOLENCE

A: PREVALENCE AND IMPACT

1 in 15

people are exposed to domestic violence over the course of childhood[2]

15.5

Million children are exposed to domestic violence each year[1]

56.8%

of children exposed to DV were also victims of maltreatment[3]

CHILDREN WHO ARE EXPOSED TO DV MAY HAVE...

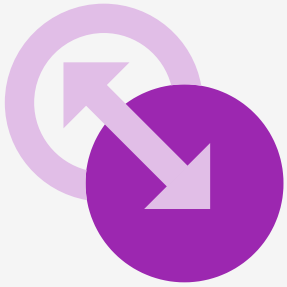
- A HIGHER RISK OF EXPERIENCING DV AS ADULTS
- A HIGHER RISK FOR BEHAVIORAL PROBLEMS
- A HIGHER RISK FOR EMOTIONAL ISSUES
- A HIGHER RISK FOR LONG TERM HEALTH ISSUES
- LOWER GPA IN SCHOOL
- MORE SCHOOL ABSENCES

18% OF CHILD ABUSE REPORTS

accepted for investigation by the Delaware Division of Family Services in FY2025 alleged domestic violence.

28% OF SUBSTANTIATED CASES

in FY2025 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

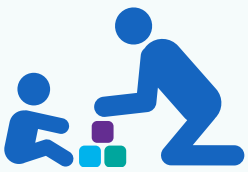
AGES 6-11

- 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

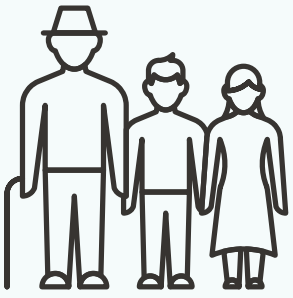
PROTECTIVE FACTORS



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: 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.

SCREENING CONSIDERATIONS IN PEDIATRIC SETTINGS OR WHEN A CAREGIVER IS WITH CHILDREN

- ✓ Always review confidentiality limits before screening.
- ✓ In pediatric settings, consider non-verbal screening options like printed cards or electronic options to avoid discussing IPV in front of the children over the age of 2.
- ✓ Only screen when one caregiver is present and in a private setting.
- ✓ Universal Education Approach: provide educational information and local DV resources in multiple formats, posters, handouts and safety cards so all families have access to information regardless of disclosure. When giving information directly, ask the caregiver if it is safe to leave information.
  Refer to Chapter IV - Screening for evidence-based screening practices.

RESPONDING TO DISCLOSURES AND REPORTING

Delaware law does <u>not</u> require mandatory reporting of domestic violence. But some incidents involving children do trigger a mandated report. *Refer to Chapter V - Legal Mandates for more information.*

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

If you must make a report, let the non-offending parent know. Follow trauma-informed reporting guidelines listed in the Legal Mandates Chapter.

CHAPTER X: ELDER ABUSE

A: RISK FACTORS AND SIGNS

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

For more information about mandatory reporting, see the **Legal Mandates** chapter.

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 does not need to 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.[1]

68.3% of them were seen at an emergency department.[1]

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, S.A.N.E.
- ✓ 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	BEHAVIORAL
Multiple or recurrent STIs	Depressed mood/Flat affect
High number of sexual partners	Anxiety/Hyper-vigilance/Panic
Trauma to vagina and/or rectum	Affect dysregulation/Irritability
Suspicious workplace injuries	Frequent emergency care visits
Signs of physical trauma or neglect	Unexplained/Conflicting stories
Somatization symptoms	Lacks ID or documents with name
Suspicious tattoos or branding	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

NHTRC FLOW CHART FOR HUMAN TRAFFICKING 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 use of tactics to manipulate or control a partner's use of substances as a method of a coercive control.

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

47% - 90% of women in SUD treatment have experienced DV in their lifetime[1]

90% of women attending a methadone clinic experienced DV[3]

60% of participants in the Substance Abuse Coercion Study report their partners had tried to interfere with their treatment[3]

SUBSTANCE USE COERCION MECHANISMS OF CONTROL

INTRODUCING PARTNER TO DRUGS AND/OR ALCOHOL; FORCING USE

FORCIING 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 your 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.

This image was created by the Delaware Coalition Against Domestic Violence.

CHAPTER XIII: MENTAL HEALTH COERCION

Mental Health Coercion is the active use of a partner's mental health as a tactic of coercive control.

Individuals experiencing any type of DV are nearly

3x

more likely to report symptoms of severe depression[1]

50%

of individuals experiencing DV say that their partner threatened to report their MH to limit things they wanted/needed[3]

90%

of women hospitalized after a suicide attempt reported current, severe DV[2]

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) 678-3886 : Northern Kent
(302) 244-8058 : Kent & Sussex
(302) 745-9873 : Bi-lingual

ADDITIONAL RESOURCES CAN BE FOUND IN CHAPTER XVII AT THE END OF THIS MANUAL

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 (EOB)

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/

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

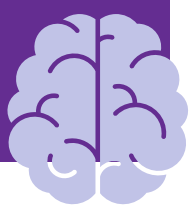
Healthcare providers should be particularly careful in situations where confidentiality could accidentally be broken and cause harm, such as, in general practice, where health professionals might treat other members of a patient's family – including the perpetrator of the domestic violence. Some perpetrators 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 providers 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 a patient's medical information, when that 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/



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

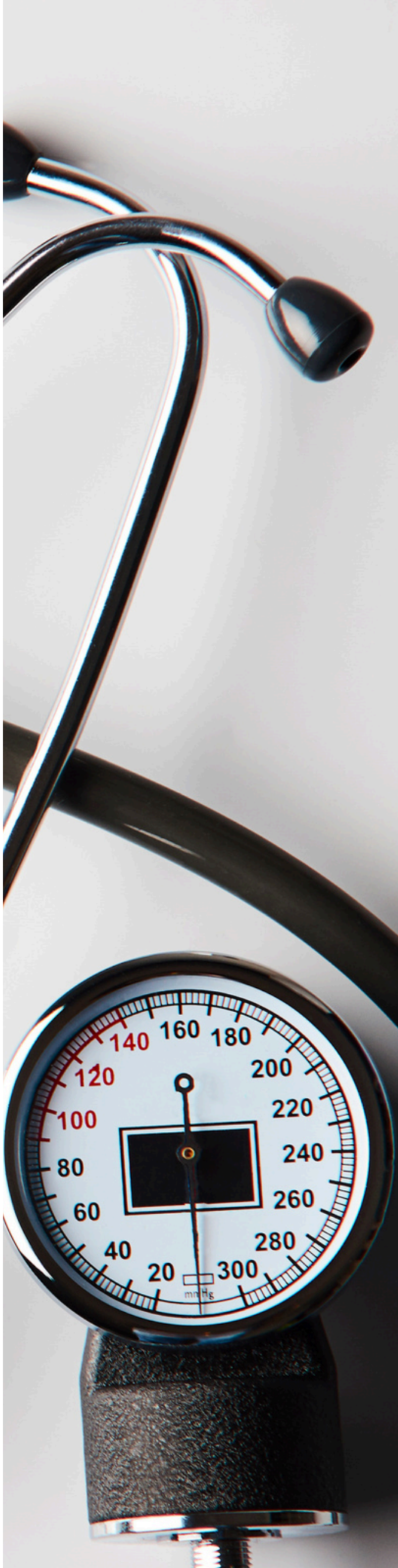
Well-documented medical records are essential. They prompt appropriate referrals for mental health treatment and services. Additionally, they increase the effective and necessary coordination of care between providers. Moreover, they provide concrete evidence of violence and abuse and may prove to be 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 and mental health 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 Chapter VI - Sexual Assault in 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.**

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.

CHAPTER XVI: LETHAL VIOLENCE PROTECTIVE ORDER (LVPO)

A. WHAT IS AN LVPO?

An LVPO is a tool to prevent lethal violence in times of crisis. An LVPO prohibits a person from controlling, owning, purchasing, possessing, or having access to a firearm, on a temporary basis. LVPOs assist in situations where a person is going through a mental health crisis, is suicidal or could be a threat to others. The order grants specific restrictions to ensure safety and mitigate the risk of lethal violence. Law enforcement officers request emergency orders and family members or other concerned persons may petition the court for a non-emergency LVPO.

Emergency

If you are concerned that a patient may be an imminent threat to their own or another person's safety, and they own or have access to firearms, you can contact the local police department with jurisdiction and they can petition for an Emergency LVPO.

Only law enforcement can petition for an Emergency LVPO. If granted, a law enforcement officer can remove the firearms right away. A hearing is held within 15 days. If the crisis has passed, the firearms can be returned.

Non-Emergency

Family members, persons with a child in common, persons in a substantive dating relationship, or law enforcement can petition in Superior Court.

Hearings are held at Superior Court within 15 days of filing.

LVPOS CREATE SAFETY

The presence of a gun is a significant risk factor for suicide. In domestic violence situations the presence of a gun increases the risk of homicide by 500%.[1]

- LVPOs do NOT remove or harm the person in crisis.
- Only the firearms are removed.
- No one is put in handcuffs or sent to jail.
- LVPOs do NOT create a criminal record.

B. WHERE DO I GO TO FILE A PETITION?

NEW CASTLE COUNTY

Leonard L. Williams
Justice Center
500 North King Street
Wilmington, DE 19801

302-255-0800

KENT COUNTY

414 Federal Street
Dover, DE 199011

302-735-1900

SUSSEX COUNTY

1 The Circle, Suite 2
Georgetown, DE 19947

302-855-7055

https://courts.delaware.gov/superior/

C. RESEARCH AND RESOURCES

Many states have Extreme Risk Protection Orders (ERPOs) like Delaware's Lethal Violence Protection Order. In a growing number of states, clinicians can directly petition the courts for an Extreme Risk Protection Order on behalf of a patient.

There is promising evidence that ERPOs are reducing both suicides and mass violence. Johns Hopkins' National ERPO Resource Center catalogs these studies.[2]

RESOURCES FOR CLINICIANS

Johns Hopkins' Center for Gun Violence Solutions operates the National ERPO Resource Center which offers many resources specifically for Clinicians, including a paper by the American Medical Association:

https://erpo.org/implementer/clinicians/

The LVPO is an option to be able to mitigate a potentially dangerous situation. Talking with the patient or family member about this option is a delicate but important step. It may validate how the person is feeling and help them gain a sense of control while managing an overwhelming set of thoughts and feelings.

The LVPO is one tool in the toolbox. It presents an opportunity to assist the patient by giving them time and resources to help them cope with how they are feeling, including therapy, medication, or crisis management resources.

CHAPTER XVII: RESOURCES

Domestic Violence & Sexual Assault 24 Hour Hotlines

Sexual Assault - Statewide

YWCA Sexual Assault Response Center
24-Hour Hotline
1-800-773-8570

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

DV - New Castle County

24-Hour Domestic Violence Hotline (& Spanish) 302-762-6110

DV - Kent & Sussex Counties

24-Hour Domestic Violence Hotline
302-422-8058 / 302-678-3886

Bi-Lingual Hotline (Spanish)
302-745-9874

Legal Resources

Community Legal Aid Society (CLASI)
New Castle County: 302-575-0660
Kent County: 302-674-8500
Sussex County: 302-856-0038

Domestic Violence Legal Services (DVLS)
New Castle County: 302-478-8850
Kent & Sussex Counties: 888-225-0582

Delaware Legal Help Link
1-888-225-0582

Court-Based Advocacy Services (DVAP: assists with PFA petitions)
New Castle County: 302-255-0420
Kent County: 302-672-1075
Sussex County: 302-856-5843

Domestic Violence Community Health Advocates

New Castle County

302-757-2137

Kent & Sussex Counties

302-422-8058

Police-Based Victim Services

24/7 Victim Center & Police-Based Victim Services
1-800-VICTIM-1 or 1-800-842-8461

Reporting Resources

Child Abuse Reporting
1-800-292-9582

Adult Protective Services
1-800-223-9074

Animal Abuse Reporting
Delaware Animal Services (Statewide)
302-255-4646

City of Newark
302-366-7111

City of Dover
302-736-7111

Toll Free Consumer Hotline
1-800-220-5424

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

DOJ Senior Protection Initiative
Email:
seniorprotection@delaware.gov

DOJ Victim/Witness Assistance Program
New Castle County:
302-577-8500

Kent County
302-257-3293

Sussex County
302-752-3263

Para asistencia en Español
1-877-851-0482

Delaware Resources

Forensic Nurse Examiners (FNE)/ Sexual Assault Nurse Examiners (SANEs)

New Castle County

Nemours/A.I. DuPont Hospital for Children
302-651-6901

Christiana Care - Newark
302-733-4799

Christiana Care - Wilmington
302-320-1099

Kent County

Bayhealth/Kent General Hospital
Kent-302-744-7122
Sussex-302-430-5720

Sussex County

Nanticoke Tidal Health
302-629-6611 ER x2555

Beebe Healthcare Lewis Hospital
302-745-3300

Beebe Healthcare-South Costal
302-291-6900

Other Delaware Resources

Child Crisis Helpline
24/7 Mobile Response Stabilization
1-800-969-HELP (4357)

NCC Human Trafficking Hotline
302-395-2727

The Beau Biden Foundation
(302) 477-2018

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

Mandatory Reporting Resources & Training

Mandated Reporter Resource Guide

Spanish Mandated Reporter Resource Guide

Mandatory Reporting Flow Chart

National Domestic Violence Hotline
1-800-799-SAFE (7233)
Text: START to 88788

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

Human Trafficking Hotline
1-888-373-7888

Crisis Text Line
Text HOME or DE to 741-741

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

LGBTQ National hotline
888-843-4564

Trans Lifeline
877-565-8860

Crisis/ Suicide
Dial or Text 988

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Domestic Violence Coordinating Council

www.dvcc.delaware.gov